ARCHIVES OF SURGERY.

APRIL, 1891.

CASES ILLUSTRATING THE HEREDITARY TRANSMISSION OF SYPHILIS.

THREE cases, in one family, which I have recently had under observation, are of great interest in reference to our knowledge of inherited syphilis. They place in a striking light the possibility of entire absence of symptoms in the infantile period. They also seem to teach that inheritance may be possible at longer periods after the original disease in the parents than is usually the case. On neither of these points is their testimony novel, but it is nevertheless, I think, of sufficient value to make them worthy of narration.

Mrs. R——, in the first instance, consulted me about herself. She was a delicate-looking woman, and had suffered for many months from glandular abscesses in the right side of her neck. There was extensive ulceration, with considerable thickening of the parts. The edges of the ulcer were undermined; the conditions very closely resembled those present in struma, and no thought of syphilis crossed my mind. She was already residing at a healthy seaside place, so that I could not suggest any improvement in this respect.

About four months after Mrs. R—— had first consulted me, she brought with her her eldest daughter, a girl of twelve. This child was said to have always enjoyed excellent health, and had never had any illness excepting scarlet fever. She was a well-grown girl, and presented no peculiarities of teeth

or physignomy, excepting great over-development of the frontal eminences. She suffered, however, from phagedænic ulceration of her soft palate, and the conditions presented made me feel certain that she was really the subject of inherited syphilis. I ascertained that she had been born about a year after her mother's marriage, and had had no infantile symptoms whatever. I never saw her father, but Mrs. R—— told me that he was a very robust man, and had always been so since she had known him. Guided by the insight obtained from the daughter's case, I at once prescribed for the mother on the supposition that what looked like struma was really syphilis, and with the result that the ulcerations which had resisted all other kinds of treatment very rapidly healed. The daughter's throat was treated as usual by the iodide of potassium internally, local applications of iodoform, and repeated cauterizations by the acid nitrate of mercury; but although my recommendations were most carefully and ably carried out by the local practitioner in charge, we had great difficulty in stopping the disease, and did not obtain cicatrization until almost the whole of the soft palate had been destroyed.

Towards the end of the treatment of her eldest daughter's case, Mrs. R—— brought to me a younger daughter. This girl was rapidly becoming deaf. She had been for two months under the care of a specialist, in the belief that the ears were not in my line. Her case was, however, a typical one of that form of deafness which occurs in inherited syphilis. Both ears were equally affected, and in the course of two or three months, without any changes which could be ascertained by examination, she became almost totally deaf. This girl was six years of age, and although remarkably well grown, she had not yet cut her upper incisor teeth, so that I cannot speak as to whether or not they may present any peculiarities. Her physiognomy certainly showed none, with the exception that, as in her sister, the frontal eminences were very conspicuous, like budding horns. She was stated to have been a very healthy infant, and had suffered from nothing excepting a sort of relapsing urticaria.

Having thus, from the nature of the disease with which the

two sisters were affected, and from the rapid cure of that from which the mother suffered, obtained conclusive evidence that all three were the subjects of syphilitic taint, I made further inquiries as to the family history. The mother assured me that excepting the ulcers in the neck she had never ailed anything during her married life, and I feel sure that she was quite innocent as to any suspicion of the real nature of the malady. Of course I did not ask her any direct questions, and, as has already been said, no opportunity occurred of seeing her husband. Inasmuch as her first-born child was clearly the subject of inherited taint, probably the father had suffered from syphilis within two years of his marriage, although, at that time and since, wholly free from symptoms. The infected fœtus no doubt contaminated its mother, and she, although never manifesting any secondary symptoms, and although never knowing that she had been ill, developed tertiary gummata ten years later. In the interval she had borne several children, of whom one, a boy now eleven, had always been perfectly healthy. Two had died, one still-born, and one, a seven-months' child, of convulsions at the age of four months. I could not elicit on the closest inquiry respecting the three living children, and the one which had died, that any one of them had exhibited in infancy any symptoms whatever.

It will be seen that the girl who is the subject of deafness is seven years younger than the one in whom the phagedæna of the palate occurred; thus proving that the power to transmit the taint of syphilis must have persisted during this length of time in one or both of the two parents. My impression is that this persistence is most probably in the mother. In her the taint had been received probably a year or two later than in the father, and she had had no treatment whatever. In a note at p. 66, ARCHIVES, Vol. II., I have discussed the question as to whether women are not liable to transmit syphilis during much longer periods than men, and answered it, though with some diffidence, in the affirmative. In that case, a mother who had been the subject of primary syphilis bore tainted children to a healthy man eight years after the acquisition of her disease. I have

certainly never known a case in which a man marrying eight years after his syphilis became the father of a syphilitic child. I have never known such a period approached, and am accustomed to tell men with confidence that they may marry at the end of the second year. Very few indeed have been the exceptions in which I have had any reason to doubt the safety of this rule. In the case of women, I have repeatedly known the power to transmit the disease last much longer. It must be remembered, however, that women as a rule seldom get the long and efficient treatment which men willingly submit to, and that not unfrequently the taint, being wholly unrevealed and unsuspected, may escape treatment altogether.

It may perhaps be for the reader's convenience that I should state in the form of propositions the facts which seem to me to be proved by the cases under consideration:—

1st. That a mother may receive syphilis by fœtal contamination and never show any symptoms until the formation of a glandular gumma thirteen years later.

2nd. That a mother the subject of syphilis by conception, and having had no treatment, may transmit syphilis to an infant born seven years after the one which infected her.

3rd. That a succession of children really the subjects of taint, as definitely proved in two of them, may pass through infancy without the slightest manifestation of it.

4th. That the physiognomy of inherited syphilis and the notched teeth may be wholly absent.

5th. That considerable value for purposes of diagnosis attaches to the prominence of the frontal eminences.

6th. That the conditions of phagedænic destruction of the soft palate in young people, and of symmetrical deafness, are both of them really consequences of inherited taint, and may be trusted as, in themselves, constituting proof of it. Had either of these girls come under care without the corroborative testimony from her sister's and mother's ailments, it might easily have been urged that the case was exceptional to the statement that these maladies are always of specific origin.

The cases of Mr. and Mrs. B—— and their infant are of

some interest in connection with the preceding narrative. Mr. B—— married on November 14, 1889, with the full permission of a very competent specialist. He had, however, only six months before his marriage been under treatment for a gleet and for some eruption on one thigh. With these symptoms there went also a sore throat, and although it was fully acknowledged that he had had complete syphilis four years ago, the distinguished specialist just alluded to told him that he thought he must have had some recent contagion. Mercurial inunction was used, and, as the symptoms disappeared very quickly and completely, I suppose his adviser must have changed his opinion as to there having been a recent infection, for he gave him, as already said, permission to marry soon afterwards. At the time of his marriage Mr. B—— appeared to be in excellent health, and he remained so ever afterwards. He was liable to attacks of slight balanitis. He married a widow lady a few years younger than himself, who was in excellent health. In the beginning of April, that is some six months after marriage, Mrs. B——, who was then pregnant, was brought to me covered with a syphilitic rash. It was stated that the eruption had come out suddenly a fortnight before, after taking a bath. She had suffered from leucorrhœa, and had some irritation on the genitals, but I did not detect any definite remains of a chancre. She was six months pregnant, and in good general health. At this date I examined Mr. B——, and found not the slightest traces of syphilis about him. I advised both husband and wife to take mercury. In the case of Mrs. B—— a slight ptyalism resulted, and her eruption disappeared entirely. From that time forward she had no other symptoms; and I believe that she did not take her pills with any great regularity. On June 2nd her infant was born, and proved to be a fine baby. It was brought to me, however, six weeks later on account of supposed paralysis of the left arm. I found that the inability to use the arm depended upon tenderness about the epiphyses. There was distinct swelling above and below the elbow. The child had bad snuffles, and its finger nails looked pinched and convex. It was beginning to waste, and

was very fretful. I of course at once prescribed for syphilis. The treatment agreed well, the periostitis soon disappeared, and in the course of a month the infant was again thriving. No relapse of symptoms occurred.* The chief point of interest in this case was, as to whether or not the husband had had a second attack of syphilis. If he had not, then his wife and child suffered in consequence of disease which had occurred four years previously. He was not aware of having had any second chancre, but he freely admitted frequent exposure to risk, and only a few months before his marriage, after two or three years of immunity from his first attack, he had been under treatment for gleet, eruption, and sore throat. My impression is strong that in all probability he had had a second infection, and that the permission to marry so soon after suspicious symptoms was not judicious. It is further, I think, highly probable that the disease in his wife was due to direct infection from a primary sore, rather than to fœtal contamination. She suffered from vaginal irritation, and had a roseolous eruption which was distinctly of a secondary kind. It is not, I think, usual, in cases of contamination of the mother by the fœtus, that symptoms of the secondary group should occur. The mother more usually, as in the preceding case of Mrs. R——, remains apparently in good health, but develops tertiary symptoms at some later date.

It is not without its interest to note that had the husband in this case preferred to conceal the fact that he had had symptoms within a year of marriage, and to deny exposure to risk, we should have been obliged to admit the case as one proving that it is possible for one who had syphilis four years ago, and had been in good health three years, to beget a syphilitic child and to contaminate his wife. Mr. B——

* It may perhaps be well to give the details of the prescription, which in this case suited admirably:

Iodide of Potassium	gr. ½.
Sol. Bichloride of Mercury	m x.
Spirits of Wine	m iv.
Water	ʒ i.

This dose the infant took three times a day, without any disagreement, continuously for about two months.

when I saw him was absolutely free from symptoms, and showed only the scars of rupia which had occurred four years ago. Now nothing is more common than for men to willingly admit having had syphilis at some distant period, and yet try to conceal the fact of recent exposure; especially if the latter have occurred during a marriage engagement or under circumstances which they think imply special disgrace. The more distant the contagion can be placed, the less, as a rule, is the reluctance to acknowledge it. Hence a very frequent source of fallacy in the clinical histories of syphilis.

The occurrence of anything of the nature of glandular gummata in the tertiary stage of syphilis is in my experience very rare. In the first of the two narratives just given we have one of the best examples of it which I have ever seen. A large mass of glands in the neck had broken down and involved the cellular tissue just as seen in struma. In ARCHIVES, vol. i. p. 73, I noticed a very remarkable case recorded by Dr. M'Call Anderson, in which an enormous mass of glands had disappeared under specific treatment, and in my last issue (p. 204) the subject was again referred to. It seems worth while to append the following fragment in reference to it.

A girl who was at Moorfields some years ago, with undoubted inherited syphilis, presented a large tumour in her neck. It was adherent to the neighbouring parts, but it was smoothly rounded and tense, and there was at first no evidence of its being made up of several glands. It had increased rather rapidly during about a month. Under iodide of potassium it diminished very much in a week, and then it became clear that it was glandular. As the infiltration around it disappeared, a whole cluster of enlarged glands were to be recognized. It was no doubt a lymphatic gumma. It wholly disappeared under treatment.

THREE CASES OF ACROMEGALY.

Illustrating the stage of Premonitory Symptoms.

I HAVE had three cases of acromegaly under my observation during the last year. The first case was that of a lady, whom I had seen on a single occasion three or four years ago, without then making any diagnosis beyond that of rheumatism. This lady has recently come under the care of my friend Dr. Hughlings Jackson, by whom she was brought back to me as an example of Dr. Pierre Marie's malady. Such she now undoubtedly is, her extremities being conspicuously enlarged, and her face lengthened. As she is now Dr. Hughlings Jackson's patient, and he will probably publish the case, I shall not give further details as to her present condition. It may be of interest, however, to transcribe from my note-book the particulars as regards her premonitory symptoms, as they were observed four years ago.

"Mrs. S——, æt. 32, suckling her child six months old, was sent to me November 15, 1883, by Dr. Cæsar, of Tottenham. She complained of intense pain from the elbows downwards, and the right fingers were flexed into the palm. The other hand was sometimes affected in the same way. There was sensation of 'tingling numbness and intense burning' in the right hand. She had twice been threatened with rheumatism, but had then no joint affection. She had always been a chilly subject, and often thought that her blood did not circulate properly. She had been well at the beginning of her lactation. The hand sometimes became 'chalky looking,' white in colour, and she could not tell whether she had anything in her fingers or not. The first time she felt this was after sleep, when she thought her circulation had stopped. There was no difference between the two radials. She was often chilly and afterwards flushed."

My second case was that of a gentleman named Mr. A—— G——. Mr. G—— is aged 40, and has been married fourteen years. I first saw him in August, 1889, and again in June, 1890. He consulted me on account of defects of circulation in the extremities, with peeling patches in the ends of the fingers. On every occasion that I saw him I noticed the extraordinary size of his fingers and the length of his face, and several times pressed him as to whether he had not noticed any increase in their growth recently. This at first he denied, but on a later occasion he admitted that the size of his gloves and shoes had been considerably increased. He tried the experiment with some old boots, and found that he could not put them on. He brought me some photographs taken at intervals several years ago, and from them there could be no doubt that during the last six years the size of his face had conspicuously increased, especially in the lower part. It appeared, however, that he had always had a somewhat heavy lower jaw, and he said that his father, like himself, had large hands. The great size of his tongue was always a feature which attracted my attention. His countenance remarkably resembled that of Mr. C. B. (see ARCHIVES, i. p. 141), the skin of his forehead being coarse, thick, and thrown into folds. The measurement of Mr. G——'s knuckles was $9\frac{3}{4}$ inches. The symptoms for which Mr. G—— consulted me were the following:—He complained that he was liable to have the blood leave his hands and feet, and said that he felt weak and faint when it did so. He said that he was losing confidence in himself, and was becoming nervous. He was in the habit of rubbing the back of his neck violently when at business, in order to "revive his brain," as he said. In consequence probably of the constant disturbances in his circulation, the pulps of his fingers had become dry and cracked. He had not experienced any severe headache, but, like my patient Mrs. A——, he had a longing for quiet and holiday. His tongue was habitually furred and white, although he had a good appetite. He suffered somewhat from piles.

It will be seen that in these two cases the premonitory

symptoms were not dissimilar. They consisted chiefly in derangements of circulation in the extremities with lassitude.

My third case is that of the widow of a Welsh farmer, who was sent to me by Dr. W. Evans, of Anglesea.

Mrs. H—— first came to me in May, 1887. She fancied she had gout, but I could find no proof of it, and prescribed a tonic. I did not then notice anything further than that her features and hands looked coarse and large.

In August of the same year she saw my son Procter, and had a polypus removed from her right nostril.

Mrs. H—— came to me again three years later (September, 1890), and I then at once recognized that she was the subject of acromegaly. She said, when I suggested it, "Oh, yes; I have been growing very much; my hands and feet are getting much bigger than they were." The enlargement was symmetrical in all parts, and appeared to shade off insensibly into the parts not involved. Her wrists and forearms were very large, and so was her whole head, without any bulgings. Her mouth and lips showed the condition most conspicuously. Her skin was very coarse and greasy. It was also constantly moist with perspiration. She was wearing large cloth shoes which laced, but which she could not nearly close. She considered herself rheumatic, but there was no stiffening of any joints. Her chief suffering was from facial neuralgia, which occurred in violent paroxysms, often keeping her awake at night. It was chiefly, but not exclusively, in the left side. She had not menstruated for three years or more. Her age was 46. Her legs, like her forearms, were very large. It is to be understood that the overgrowth was of skin and subcutaneous tissues quite as much as of bones. Although her face looked so large, and her lips especially, yet I could not on examination from within the mouth appreciate any thickening of the lower jaw. The left coronoid process appeared to be enlarged, but not much. The girth of her hands around the knuckles was nine inches and a half, and that of her index fingers three and a half.

Mrs. H—— was a large, coarsely-built woman. She said that she had of late got weaker, but still attended to her household duties. The slightest exertion made her perspire.

A MOST REMARKABLE INSTANCE OF KERATOSIS OF THE PALMS AND SOLES.

I DESIRE to rescue from that oblivion which has overtaken not a few of the excellent clinical observations of our forefathers a most remarkable case. It is that of a man who throughout the greater part of his life suffered from an affection of his palms and soles, attended by thickening and overgrowth, and finally by the development of outgrowths almost polypoid. The condition of things finally assumed is well shown in the lithographs which I have copied from the original Memoir. I have never myself seen any similar case, I mean not one which had attained anything like a similar development. I showed the portraits before the Dermatological Section at Berlin, where I believe they were quite new to all who saw them. I did not on that occasion get from my friends any hints either as to the true nature of the malady or as to the existence of other recorded examples of it, nor have I met with any reference to this case in our systematic works on Dermatology. Yet it is little more than half a century since the case was published in a well illustrated quarto monograph, by an authority of no less distinction than Dr. Wilhelm Sömmerring, of Frankfort. The patient had, I believe, never been seen by Dr. Sömmerring himself. He had been under the care of Dr. J. D. J. Behrends, to whose zeal we are indebted for the preservation of portraits done in oil by an artist named Bager. This was thirty years before their publication. Dr. Behrends died in Salzburg, about 1823; and the paintings then fell into the hands of his son, who showed them to Dr. Sömmerring, and at the same time communicated the particulars of the case. Unfortunately the latter were supplied in part from memory. They are not as complete as could be wished; nor is there

extant, so far as I am aware, any sequel to the case. The patient was still living when it was published. Dr. Sömmerring in recording it, enters at considerable length into the literature of ichthyosis, to which he supposes the disease to be allied.

The following are the chief facts in reference to the patient, which were supplied by Dr. Behrends, junior. He was a man who at the time the portraits were taken was aged fifty-three. He stated that he remembered in early boyhood to have been troubled with rounded swellings in his soles and palms. These had throughout life given him considerable annoyance by becoming painful during his work. The remarkable outgrowths which had finally disabled him had developed chiefly during the last three years.

The man was apparently healthy. He was well-made and muscular, and had throughout his life scarcely ever suffered from illness with the exception of an attack of small-pox at the age of seventeen. The tumours, which are described as being chiefly situated on the inner aspects of the hands and feet, were of a greyish white colour and very sensitive. They were said to be much more painful during damp weather than when it was dry. They readily bled when small incisions were made into them. The growths extended from the nails along the anterior surface of the fingers, and on the feet as far back as the heels. The nails were distorted and enlarged; and those of one hand especially were greatly hypertrophied and curved.

The above are all the important particulars which I have found on record, and it is scarcely worth while that I should attempt any detailed description of the appearances which are so well shown in the plates. As regards the nature of the disease, it may seem probable that the man was the subject of congenital peculiarity of the skin of the parts affected. During the earlier periods of his life the term keratosis, or possibly that of ichthyosis, was applicable. By degrees, under the influence of the continued irritation of standing in the case of the soles of the feet, and the use of tools, &c., in the case of the palms, gradual increase in the hypertrophic conditions took place. Finally, when the influence of senility began to be felt by the tissues, conditions of over-

PLATE LX.

THE SÖMMERRING-BEHREND CASE.

A REMARKABLE DISEASE OF THE HANDS AND FEET.

This Plate shows the condition of the feet in Behrend's case, as described in the text. It will be seen that large bossy masses of hypertrophic out-growth are developed on all parts of the sole not actually exposed to pressure. These out-growths form a sort of fringe round the borders of the foot and toes. The growth, as seen in fig. 2, is especially large on the inner side of the great toe. The parts of the sole actually exposed to pressure in standing are, for the most part, comparatively free from change. The under surface of the heel itself is, however, involved. The dorsum of the foot and toes is unaffected, with the exception of that of the great toe.

Fig 1

Fig 2.

West, Newman, lith.

A remarkable disease of Hands and Feet.

PLATE LXIII.

THE SÖMMERRING-BEHREND CASE.

A REMARKABLE DISEASE OF HANDS AND FEET.

THE hands, from Behrend's case of remarkable disease of the hands and feet. The whole of the palmar aspect of the hands and digits, with but very little exception, was involved in hypertrophic growth, which, in some places, had assumed the form of polypoid, or finger-like excrescences. It will be seen that there are a few nodules on the back of the hand, and that the finger-nails are thickened, fibrous, and over-grown. Plate LX. shows the condition of the soles of the feet from the same patient. They were from a man somewhat past middle life, in whom the disease had been in progress probably from childhood. The sequel of the case is not known. This Plate may be suitably compared with that from Dr. Judson Bury's patient (see Plate LXI.).

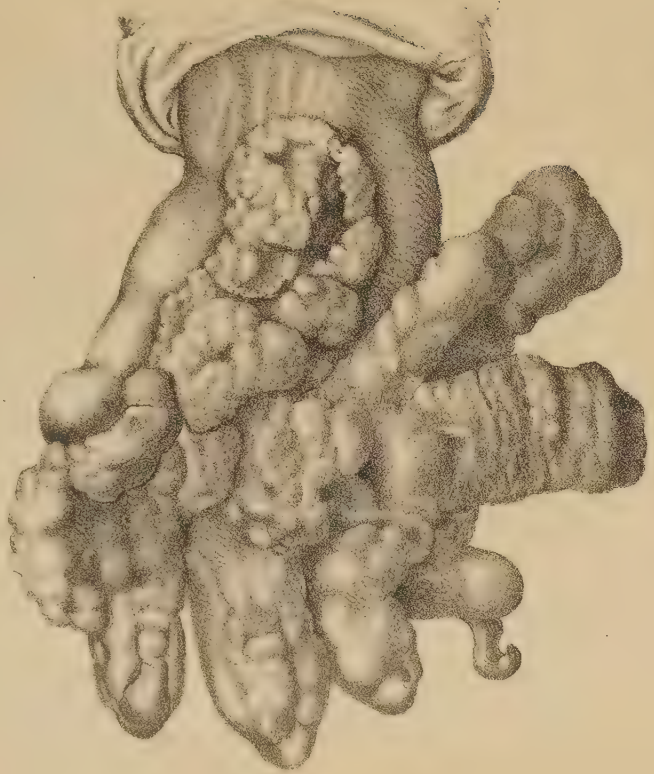


Fig. 1

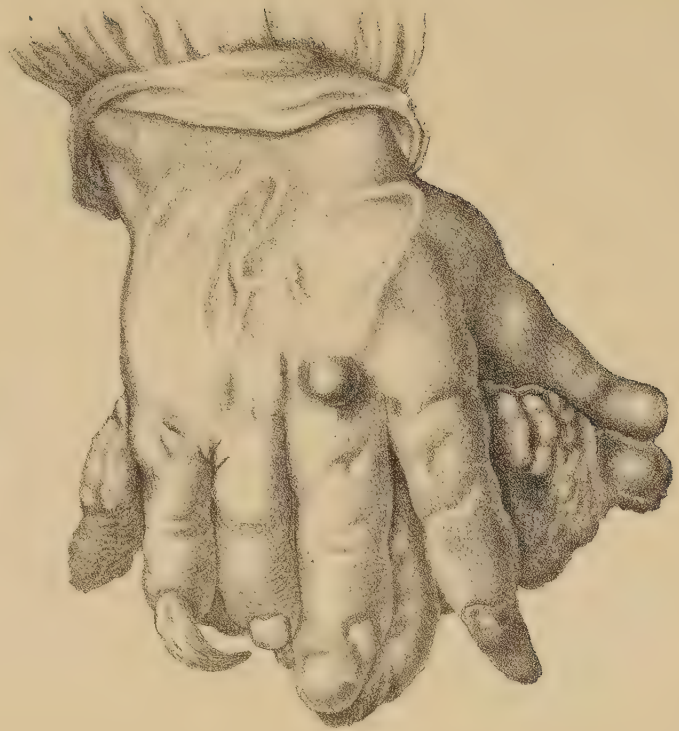


Fig. 2.

West, Newman, lith.

PLATE LXI.

PECULIAR DISEASE OF SKIN OF HANDS, &c.

I have copied this portrait from a drawing given me by Dr. Judson Bury, of Manchester. It is the one to which I have referred in the text, at p. 301; and the case is reported in detail in the 'Illustrated Medical News' for May, 1889. Dr. Judson Bury has been kind enough to supply me with particulars which bring the case up to date. The patient is a child who was twelve years' old when the hands were sketched, and is now fifteen. But very little change in the local conditions has occurred during the last three years. A few of the patches have entirely disappeared, but most of them remain as they were; some of them have become decidedly thicker and more nodular. The girl is in good general health.

Her curious eruption began in July of 1888, and consisted of purple erythematous patches, with considerable thickening, on the palms of the hands, backs of elbows, and fronts of knees. There were the remains of a patch, which had faded, over the left loin. The toes were slightly livid and swollen, and it was stated that the disease had first shown itself on them, and subsequently spread to the knees. On the backs of the digits there were some thickened, almost nodular, patches of a similar character. Thus the fingers presented a lumpy, knotty condition. The patient's family history was good; she was the youngest of twelve, and neither gout nor rheumatism had occurred in her relatives. She had herself, however, had an attack called rheumatic fever, after scarlet fever, at nine years of age.

It is very difficult to speak as to the precise nature of this disease. It certainly very closely resembles, in general features, some cases which I have myself published,* without venturing to give the disease any name; but which were, I have no doubt, of

* 'See 'Illustrations of Clinical Surgery,' Plate VIII., and page 42. Also the 'British Journal of Dermatology,' November, 1888.

the same nature as the disease figured by Hebra as "Sarcoma Melanodes," and which now ranks as one of those which make up the Dermatologist's group of "Sarcoma Cutis." I can scarcely doubt that Dr. Bury's case is of the same nature as my own, but I have never myself seen any approach to it in a young person. The persistence of the condition during three years, and in spite of much treatment, separates it of course very widely from all forms of psoriasis and erythema.

I have special interest in publishing this portrait at the present time, because it seems to me very possible that the disease shown may be an introductory condition to the extraordinary state which occurred in the Sömmerring-Behrend case, published at page 219.

Fig. 1

Fig. 2.

Remarkable disease of Hands.
(Copied from Dr Judson Bury.)

West, Newman, lith.

growth ensued which were possibly not far removed from those which histologists of the present day would term Sarcoma. The rapid development of overgrowths during the last three years in parts which had manifested no such tendency during early and middle adult life, demonstrates a tendency towards malignant processes. Unfortunately the sequel of the case is not known. If it were forthcoming, it is, we may suspect, not improbable that it would reveal further developments in this direction.

As illustrative of the form of Keratosis which occasionally occurs in consequence of congenital peculiarity of skin, I may refer to a portrait published in Sir Erasmus Wilson's Atlas, and to one given in the Atlas of Rare Skin Diseases, by Unna and Morris. I have myself seen several examples of it, one of the best of these being a case shown to me not long ago by Dr. Tom Robinson. The portrait published in the *Illustrated Medical News* by Dr. Judson Bury, showing livid or purplish patches in the hands of a girl, may possibly be related to it, but not so closely as those of Keratosis, since the affection was not limited to the palms.

More than one portrait of severe Keratosis of the palms and soles will before long be found in juxtaposition in the Gallery of the Royal College of Surgeons. These represent, I believe, the early stages and slighter forms of what the lithographs here given show in such extreme development.

ON SUBJECTIVE ABERRATIONS OF THE SENSE OF SMELL.

Great interest attaches in not a few instances in the observations, as to their own maladies, which medical men have made upon themselves. Many persons are capable of studying their own cases without alarm, and even of making them, under very trying circumstances, topics of interesting conversation. John Hunter's observations concerning his own pulse during a terrible paroxysm of angina are well known. He believed that the circulation had entirely stopped, and set himself deliberately to practice forced respiration in order to restore it. Observing his face in a glass, he records that he was deathly pale. No doubt he was in error in the belief that the heart's action was wholly suspended, but there can be equally little hesitation in believing that during a considerable period it was extremely feeble. On subsequent occasions it is recorded that he entirely lost memory, or at any rate was for a time quite unable to express himself, and believed that he had forgotten everything. The most important lesion which was demonstrated after death was advanced calcification of the coronary arteries. Although there was some disease of the mitral valve, his heart was smaller than usual. Of one distinguished physician—I forget whether it was Haller or Albinus—it is recorded that he studied his own symptoms on his death-bed with the greatest equanimity, and it is asserted, though perhaps it may be doubted, that he counted his pulse to its last perceptible stroke, and quietly remarked to his friend, "It has ceased to beat." Our medical biographies contain a good deal of information as to the maladies from which medical men have themselves suffered, and they would, I think, for those who have zeal and leisure for such matters, be well worth collecting. In a profession like our own, memory requires every kind of collateral aid which can possibly be

given to it. Although narratives of the kind referred to may possibly have attached to them a certain flavour of personal gossip, yet they ought not on that account to be wholly disdained. Many of our case narratives are, it must be admitted, sufficiently dull, and we can scarcely afford to despise any element which gives them interest.

The above remarks have been suggested by the accidental discovery, in the biography of one of Hunter's pupils, of the description of a very peculiar symptom in connection with subjective aberrations of the sense of smell. Before quoting it I will, however, briefly record a case which has caused me to take special interest in this topic. I have at present under care a gentleman who suffers from the recurrence during very short periods of most abominable odours. The symptom may occur at any time of the day, or even occasionally during the night. It may affect him sometimes even during meals. He turns deathly pale, feels faint, and as if he were going to die; then in the course of half a minute a sensation of coldness follows, attended by a most horrible stench. The perception of the latter is so strong that he says it is with the utmost difficulty that he can bring himself to credit the assertions of others that they do not perceive the smell also. This symptom has now persisted for several months. For a month or two at one time he was quite rid of it, and it then returned. He never falls or loses consciousness, and the whole thing does not last more than a minute. He has suffered from syphilis, and is now the subject of complicated symptoms indicative of cerebral disease. Of these, persisting vertical hemianopsia is one of the chief.

The symptom which I have just described has, I believe, received but little attention from neurological writers, and I therefore venture to quote the following narrative respecting it as it occurred in the case of Mr. Cruikshank, the celebrated anatomist. It is taken from Mr. Leigh Thomas's "Hunterian Oration" of 1827.

"The immediate cause of his (Mr. Cruikshank's) death was apoplexy, which he had always foretold would terminate his existence. He was led to prognosticate this event from the circumstance, that whenever he stooped forwards, or, in short,

when from any cause the free return of the blood from the head was interrupted, he was conscious of a peculiar thrilling sensation in the superior surface of the left hemisphere of the brain; and at this point, it was found, upon examination after death, the mischief had actually taken place. This portion of the brain had the appearance of having been torn; and the effusion of blood in the surrounding parts was very considerable. There were no other marks of disease within the cranium, excepting a deposit of osseous matter adhering to the falciform process of the dura mater.

"He had also laboured under many other symptoms denoting cerebral disturbance, and as these bore so strong a resemblance to a similar case in a near relation of his own, I am induced to enumerate a few of the most important, and to elucidate the subject, as far as the evidence of two cases will admit; and which were repeatedly and most carefully investigated.

"As friends they were almost in the daily habit of communicating with each other, and their similar distressing sensations were, as may be imagined, the frequent topic of conversation. They were both men of lively imagination and quick parts; their habits of life had been so far similar that the mind had been actively employed in both, though in very different situations.

"They were each subject to an entire loss of memory; which occasionally occurred in the midst of the most animated conversation, as well as when the mind was in a state of quietude. This suspension of intellect was merely transient, and its restoration was equally sudden.

"The sense of smelling was also very obtuse; commonly the strongest volatiles would scarcely affect the organ, yet whenever any circumstance occurred to excite painful emotions in the mind, they were liable to be assailed with, and suffered the most poignant distress from, the sensible expression of odours, which they invariably described as horribly offensive. Indeed, the pallid face and hurried state of the whole system very clearly denoted the intensity of their sufferings. They were subject to frequent and violent fits of sneezing, and Mr. Cruikshank often remarked that the organ of smell must have

numerous unknown nerves in its composition to explain the complexity of its feelings.

A very short time only intervened between the decease of these relatives; similar in death as in the precursory symptoms. Mr. Cruikshank was the survivor, and investigated with careful and deep attention the state of parts within the cranium. Here blood was found effused to a considerable extent in the left hemisphere, and a bony deposit was attached to the anterior portion of the falciform process.*

"The resemblance in each case was very remarkable; but in neither did the most careful examination detect the slightest alteration in the natural and healthy appearance of the structure of the olfactory nerve."

I have quoted the above *literatim* from Mr. Thomas's narrative. I am not aware that any further details can be obtained. We should like to know whether Mr. Cruikshank and his cousin had had syphilis. It is well known that surgeons are especially liable to be infected in accidental ways. Hunter had himself so suffered. The symptoms bear a very close resemblance to those which I have recorded in my own patient, in whom they are undoubtedly connected with cerebral syphilis. The history of the sudden attacks is suggestive of relationship to the epileptic seizure. If no one has already a better name for the occurrence of sudden epileptoid attacks marked by subjective kakosmia, extreme pallor of face, and sense of impending death, I would venture to suggest that they may be conveniently known as "Cruikshank's Malady."

The perception (subjective) of a bad smell as the antecedent of certain epileptic attacks has received special attention from Dr. Hughlings Jackson, and is now well recognized. The cases to which I refer are, however, of a quite different nature, and are not followed by any kind of convulsions.†

* See Specimen 3,849 in the College Museum.

† A case of Epilepsy preceded by Smell-warning, by Dr. Hughlings Jackson and Dr. Beevor, will be found in a recent number of "Brain" (October, 1889).

A VISIT TO EDINBURGH.

(*Concluded from page* 205.)

I SPENT an hour very agreeably and profitably in looking over a considerable collection of drawings in the possession of Dr. Byrom Bramwell. These illustrated a variety of subjects, but chiefly the appearances of disease as presented in the living patient. As in the case of Mr. Allandale's pathological specimens, I could not help a feeling of regret that objects of so much value should be retained in private hands. Dr. Bramwell may very probably publish a collection from his portfolios. This, however, will not fully answer the end to be desired. Every one of his drawings ought to be mounted, and with a full history attached exhibited in a gallery where all who wished could consult them at leisure. It is to be hoped that in connection with the University Museum a gallery of pictorial illustration will sometime be formed; and that when this is realized Dr. Bramwell will present his collection to it. In one feature his drawings had an advantage over most collections which I have seen; I allude to the fulness of the notes which accompanied them. Not a few very valuable pictorial illustrations, both published and otherwise, have lost three-fourths of their value by the meagreness of the details respecting the cases which they illustrate.

I will not attempt to describe in detail the subjects of Dr. Bramwell's collection. He was kind enough to allow me to bring away as a memento several photographs which interested me very much. One of these is the portrait of a child, the subject of ophthalmoplegia externa. It shows well the

drooping eyelids, divergent eyeballs, and general sleepiness of expression. A companion portrait taken a few months later shows the face of the same child with the lids well up, the eyes well directed, and an expression of vivacity in very striking contrast with that of the first. I have never myself seen ophthalmoplegia externa in so young a child, nor have I ever witnessed so perfect a recovery. I know of very few in which it has been developed in connection with inherited syphilis. The evidence as regards the latter taint was imperfect, but yet to my mind conclusive. There was no history of previous symptoms either in the parent or child, nor did the child's physiognomy show anything suspicious. The cure, however, took place under the iodide of potassium, and a periosteal enlargement of one of the fingers, which had been present, entirely disappeared during the treatment. It was therefore, I think, no doubt one of the not very infrequent cases described at p. 289 of the present number, in which children inherit a taint of syphilis, but display no infantile symptoms whatever. They are precisely those in which also the parental history is most often wanting.

Dr. Bramwell also gave me another photograph, and was good enough to show me the patient himself, in which a very peculiar group of nerve symptoms had occurred, such as one would have been inclined to attribute to syphilitic neuritis. There was, however, after the most careful inquiry, nothing to be made out in corroboration of such a suspicion. The photograph shows well a hollow in the temple caused by atrophy of the temporal muscle after a febrile illness. The patient had regained his health, but without recovery of this muscle, and he still had defective innervation of his tongue and cheek.

Amongst the improvements and developments which are in progress in connection with the Royal Infirmary is the erection of a new operating theatre for the Professor of Surgery, Mr. Chiene. It is to be fitted with every modern convenience in reference both to the teaching of students and the practice of antiseptic surgery. I was also very glad to see the foundations laid for a small new wing, which is to contain wards for skin diseases. These will be under the

care of Dr. Allan Jamieson, who at present holds the position of extra-physician for skin diseases to the infirmary, and has under his care a large out-patient department. The addition of wards will be of the utmost advantage for the teaching of this important speciality; and it is satisfactory to observe that dermatology is taking its proper place in the curriculum of the Edinburgh University. There is as yet, I believe, no collection of drawings or models which is accessible to the students or general public, but it is to be hoped that this want will be supplied before long. Dr. Jamieson possesses a private collection of drawings which is well arranged and described, and which would constitute an excellent nucleus for a collection, when suitable galleries for the display of such objects are provided. For myself I may admit that I regard such galleries as essential to the successful education of the profession in this branch of medicine; and trust that the time is coming when they will be accessible to the students of all our large medical schools.

I attended Dr. Allan Jamieson's out-patient clinic, and was shown several interesting cases, amongst others one of pityriasis rubra, or universal exfoliative dermatitis. The patient was a man under middle age, who had enjoyed good health until attacked by this terrible skin affection. He still, indeed, ailed nothing excepting from the inconvenience and distress which the skin disease caused him. It appeared not unlikely that it might disable him for the rest of his life. Surely it is matter for reflection for those surgeons of high dignity who regard all that relates to skin diseases with a feeling akin to contempt, to remember that after all they probably disable for the pursuits of life a far larger number than are incapacitated either by aneurisms or by stone in the bladder.

I have yet a few sentences to add to the notes already published in reference to the contents of the University Museum. Dr. Alexis Thomson showed me a number of interesting specimens which have recently been added to the collection, illustrating modern knowledge as to tuberculosis as it affects bones and joints. Some of these were from cases of pulpy degeneration of synovial membrane,

the typical characteristic of "white swelling." They became of value because accompanied by microscopic proof of the presence of tubercle and tubercular bacilli. Some of these specimens have been described with good pictorial illustrations in a paper by Dr. Thomson, printed in the second volume of the Laboratory Reports of the Royal College of Physicians of Edinburgh. When will the Royal College of Physicians, London, publish its laboratory reports? In former years it used to issue an annual volume of select papers, but it is so long ago that the fact that it ever did has been almost forgotten.

Amongst the curiosities I was shown a specimen of the bone of the penis of a walrus, in the middle of which was evidence of a united fracture. I was told it was the second specimen illustrating this accident which was known. The union was good, and with but little overlapping.

Some very beautiful examples of recently prepared injected specimens were shown me, and also some drawings and models which had been obtained by first injecting, then freezing, and then making sections. By this means the precise relations of abscesses, tubercular deposits, and new growths to the surrounding parts and to the blood-vessels had been remarkably well preserved.

The practice of making injections of pathological specimens has perhaps been too much neglected of recent years in our London museums.

I was shown also a good specimen of an infant's skull affected by syphilitic periostitis, and exhibiting "Parrot's bosses" in a very well marked manner.

The last specimen to which I shall refer is one which I have already mentioned, and which has been quite recently added to the collection through the zeal of Dr. Alexis Thomson. I was favoured with an opportunity for its private inspection at home before my visit to Edinburgh; and on account of its great rarity, I shall perhaps be excused if I introduce here a detailed description of it. Excellent photographs of it may now be inspected in the Gallery of the College of Surgeons (London).

These photographs represent a skull which affords a most

remarkable example of unilateral overgrowth. All the changes are restricted to the left half of the skull, and lower jaw. Only a few definite exostoses are present, the changes for the most part consisting of diffuse thickening, and overgrowth of the bones concerned. Thus, looked at from the front, the left half might be taken as belonging to a much larger head than the right. The upper alveolus comes much lower down, and the frontal and parietal bones stand higher than on the opposite side. At the same time the bones of the right side look thick and coarse, and lumpy ; though without any definite exostoses. This lumpy thickening is especially marked in the malar bone, and in the frontal just over the orbit. In proof of the increased size, it may be stated that the measurement from the lowest part of the orbit to the alveolus is on the left side $2\frac{1}{3}$ inches, and on the right only $1\frac{1}{2}$ inch. The malar bone on the left side from the orbit to the lower part of its zygomatic process is two inches, being double that of the opposite side. Neither the orbit nor the nasal fossæ are in any way encroached upon, nor are the thin bones of the roof and inner walls of the former, nor any part of the ethmoid or turbinated bones in the least thickened. The nasal bones are not involved in thickening, but are curiously twisted, owing to the general enlargement of the left side of the face. The occipital bone and the posterior part of the parietal bone show but little evidence of thickening, nor is there much in the mastoid process or the adjacent part of the temporal, though a certain amount of enlargement is here present. Thus the chief evidences of enlargement are in the superior maxilla, the malar, the frontal, and the left half of the sphenoid. By the projection inwards of its inner wall and outwards of its outer one, the capacity of the frontal sinus on the left side is very much increased. It measures three-quarters of an inch across, an inch-and-a-half in length, and would contain a pigeon's egg. All the foramina on the left side are very much larger than those on the right ; thus the supra-orbital notch on the left is by a bridge of bone converted into a foramen, of a size which would easily contain a crow-quill, whilst the infra-orbital would take a goose-quill.

At the base of skull the distance from middle of basilar to root of zygoma is on right side ... $2\frac{1}{2}$
" " " left " ... $3\frac{1}{4}$
From top of mastoid to most prominent part of lower margin of orbit (compasses) on right side $3\frac{3}{4}$
" " " " " left " $4\frac{1}{2}$

The space between the pterygoid plates is on the left side much wider than that on the right.

There is a very large socket for the canine tooth on left side, much larger in all dimensions than that on the right.

The skull is that of an aged woman. On the left side the socket for the canine tooth only is present, and on the right those for the canine and one molar. The others are on both sides quite obliterated.

The hinder part of the alveolus on the left side is very thick, and the thickness increases as we pass backwards. The portion of alveolus between the canine socket and the symphisis of the maxillæ is not materially thickened. As a rule the tendency seems to be for all the hypertrophies to increase in proportion to distance from middle line. There is a series of very large pacchionian pits in the inner table, just to left of middle line, in the parietal bone.

The foramen magnum is almost symmetrical.

The left hamular process is prolonged into a spur, and another long stout spur springs from the base of the external pterygoid plate. The anterior clinoid process is prolonged backwards as a thick spur.

The foramen ovale is twice as large on the left side as the right, but the general overgrowth of the left bones draws it a little to that side. Posterior to a line drawn across the middle of the foramen magnum there are no evidences of overgrowth, excepting some increase in thickness of bone. The surface for articulation of condyle of lower jaw is twice as large on the left as on the right side, and occupies the base of the zygoma, extending it outwards.

The capacity of the skull on the left side looks much greater than on the right, but this is probably due to the way in which the skull has been cut. The occipital bone is not in

the least increased in thickness on the left side. The condyles for the atlas are of the same dimensions on both sides.

The hollow for the jugular vein on the left side is very large and deep, and easily receives the end of the little finger.

The hollow for the lateral sinus is far greater on the left side than the right. Probably the patient always slept on the heavy half of the skull (Mr. Hilton's theory).

The lower jaw is much elongated on its left side, and its condyle is twice the size of that on the right. In this respect it almost exactly resembles a lower jaw figured in Adam's work of "Rheumatic Arthritis," Plate I., fig. 1.

I have had special interest in thus describing this specimen because it is nearly the counterpart of one in my own possession, which was, I believe, unique until this was obtained. They are of course the *post-mortem* relics of a condition which is extremely rare—unilateral hypertrophy of the face. They are of very great physiological interest as illustrating unsymmetrical lesions of nutrition and growth, which can scarcely be explained on any other hypothesis than that they are due to nerve influence. The tendency is, I believe, usually shown in very early life. At what period it is arrested we do not know. The patient both in Dr. Thomson's case and my own lived to be old. The cases must be kept quite apart from the far more common ones of hemiatrophy of the face consequent upon morphœa in early life. With these they have nothing in common beyond the fact that in both the lesions are probably localized by the fifth nerve.

I have not myself ever seen in the living subject a good example of one-sided hypertrophy of the face. I find recorded by Schiek * an example of it, which he observed in a girl of nine. It had begun at the age of two, and implicated the soft parts as well as the bones.

Sir George Humphry has also published † a case of unilateral hypertrophy of the gums and side of face, including the ear, palate and tonsil.

In the Gallery of our College of Surgeons, in juxtaposition with photographs of Dr. Thomson's specimen and my own,

* "Berliner Klin. Woch." No. 45, 1883.

† "Annals of Surgery," vol. iii. p. 1.

I have placed an engraving from Heuss' Atlas, showing exostoses from the skull bones on one side only, but in this instance there is not much proof of general overgrowth of bones. In conclusion, I may briefly mention another specimen taken possibly from a similar case. It is that of an unsymmetrical lower jaw, which was presented to the Royal College of Surgeons by Mr. McCarthy, of the London Hospital. It is 2205 in the Catalogue. In this case one half of the jaw is apparently much too large, and the other at the same time somewhat too small. The increase is not so much in thickness as in length, and the over-length of the right side gives to the bone a peculiarly twisted appearance. There are no nodosities or anything of the nature of an exostosis upon it. The overgrowth of the right half ends at the chin, but not in a very abrupt manner. The coronoid process of the right side, although somewhat larger than the opposite one, is not involved in the overgrowth, and is somewhat smaller than that of a healthy bone. The articular process on the contrary is much enlarged and misshapen, and might have been supposed to be affected with chronic rheumatic arthritis. Its neck is long and twisted, and shows signs of an oblique united fracture.

The history of this specimen throws no light upon the cause of the curious deformity. Mr. McCarthy tells me that it was obtained from an artilleryman who had become quite deaf, in connection possibly with his occupation, and who died in the London Hospital from an aneurism. He was about fifty years of age. The one sidedness of his face was very noticeable during his life, and led to the removal of the specimen. No alterations were observed in the skull or in his limbs.

CASES OF PARALYSIS OF THE DELTOID IN CONNECTION WITH SYPHILIS.

CASE I.—*Paralysis of the Deltoid Muscles in the fourth year of Syphilis—Complete on one side and partial on the other—Recovery under treatment.*

In the following case we have, I think, in all probability an example of syphilitic neuritis affecting the circumflex nerve. It finds, perhaps, its best parallel in the cases which we occasionally see of syphilitic paralysis of the fifth. Syphilitic neuritis of single nerve trunks, if we except those of the muscles of the eye, are very infrequent. Thus the portio dura is attacked with extreme rarity, and the nerves supplying the extremities with yet greater infrequency. A very remarkable feature in the following case is the fact that the condition was bilateral. The deltoid muscle was completely paralyzed on one side and its anterior half on the other. In both, the affected muscle became atrophied, and the skin over it was partially anæsthetic. Under specific treatment long continued the atrophied muscle became redeveloped, and regained its full power. These facts are in exact parallel with what we observe in paralysis of the fifth. I published many years ago a series of cases, some of which proved that it was possible for the temporal muscle, after having undergone complete loss of substance, and having been in the condition of atrophy for some months, to be completely restored under the use of iodide of potassium. These cases will be found in the Moorfields Hospital reports. I have never until the present instance seen a case in which I ventured to diagnose syphilitic neuritis of the circumflex nerves. On searching my note-books, however, I

have found a mention of two cases which were not improbably of this nature. These will be appended to the present narrative.

On January 28, 1890, a gentleman, aged 29, consulted me on account of inability to raise his right arm. I found on stripping him that he could not use his right deltoid in the least, and that the muscle was so wasted that its presence could not be detected by the hand; the head of the humerus and other bony points appearing to be immediately subcutaneous. The skin over the whole deltoid region was partially anæsthetic, and, as he expressed it, the shoulder felt "dead numb." In the other arm, the anterior half of the muscle was in a similar condition, whilst the rest was plump and active. The history of the case was that Mr. W—— had been treated for syphilis in September, 1886. He had, as he said, "a terrible throat," and was under the continuous treatment of a highly distinguished surgeon for six months. After that, on account of repeated recurrences of eruption, he often took mercury for longer or shorter periods, on and off. During 1888 he was most of the year in the tropics, and bore the heat well. Having returned in May of 1890, he had a few spots and rings on the arms and body which were accounted syphilitic, and for which mercury was again prescribed. In October of the same year, about four years after the original disease, he began to suffer from a variable and not very severe pain in his shoulders. In November this pain had increased, and he was obliged to keep the house. It was called rheumatism. During December the pain was very severe indeed, so that he could not sleep, and on four or five occasions its severity was such that he was obliged to call up his medical attendant in the middle of the night to inject morphia. The pain was somewhat on both sides, but much worse on the right than the left. He described it as having been most intense just at the back of the armpit, where it was, he said, just as if some one were using an oyster knife. The skin over the right shoulder became numb, and the pain gradually abated; but he found that he was quite unable to lift the arm, and in this condition he came to me as above stated in the end of January. He was at this date

in tolerably good health, and he had no other signs of syphilis. I believe that he had, during his month's confinement to bed, taken iodide of potassium in moderate doses. The surgeon who had attended him, informed me afterwards that there had never been any particular increase in temperature. The treatment had been by the salicylate of soda with, during a part of the time, the iodide of potassium. I prescribed for Mr. W——, on January 28th, mercurial pills, in conjunction with iodide of potassium in mixture. A month later the left arm was better, but the right not much; and the doses of iodide were increased. On March 28th I had still to record that the right deltoid was not improving, and that on the left side the anterior half of the muscle was still wasted. He had a syphilitic urticaria over his abdomen, and a few iodide spots on his face. The medicines were still continued, and shortly after this note both muscles began to improve. The improvement, however, was only slow, and in the autumn of the year he went to Aix-le-Bains, where he thought that he obtained much benefit from massage. After this he continued the treatment in smaller doses, and in January of the present year—twelve months from the time that I first saw him—he was quite recovered. He had then taken no medicine for two months or more; his deltoids were again of good size, and he could lift his arm well. His right was perhaps the more plump of the two. He was at this latter date anxious to marry, and I assured him that he might do so with safety.

It is a noticeable fact in the above narrative that the improvement did not commence until after the specific treatment had been used for a considerable time, and that after it had once begun it continued steadily, although specifics had been suspended. I have noticed the same protracted recoveries in other cases of syphilitic neuritis, and do not think that they in any way invalidate the diagnosis.

It seems worth while just to add a few words as to the peculiar form of disability which paralysis of the anterior half of the deltoid entails. As stated, on the left side the posterior half of the muscle was never in the least affected; and during the progress of recovery of the muscle the

posterior half on the right side was that which was first restored. Whilst in this condition he was able, with a certain amount of manœuvring, to hold his arm at right angles to his chest. It was necessary that it should be in complete supination, and if he attempted to pronate ever so little his arm dropped down to his side at once. Thus he could not venture to hand a plate at table, as he was sure to drop it in attempting certain movements. He could always put his hand behind him easily, and did not need assistance in dressing. All the other muscles of the upper extremity, excepting the supraspinatus on the right side, appeared to be in good condition; but I have to confess, in reference to this point, that I did not test them by galvanism.

When a nerve lesion is symmetrical, the suspicion of central disease of course occurs; and I should not like to express any positive opinion respecting the present case as to the precise position in which the neuritis began. The skin over the deltoids receives its nerve supply from other sources as well as from the circumflex, and we could not therefore expect that complete anæsthesia of any part should result from destruction of its trunk. The condition complained of by Mr. W——, was rather a "dead numbness" of the skin, which also was not absolutely without sensation. He said that the skin of his right shoulder always felt cold to his hand. Abolition of the functions of both motion and sensation in the tract supplied by a mixed nerve is of course an almost conclusive indication of disease in the course of its trunk. The occurrence of severe pain such as that which Mr. W—— experienced in the early part of the case, is also, I should suppose, indicative of peripheral neuritis rather than of central disease. On the other hand, we must remember that there are certain clinical facts which appear to indicate that the nuclei of origin of the circumflex nerves are in some way peculiarly liable to be implicated in disease. No muscle, perhaps, affords us so many examples of isolated paralysis as the deltoid. I have recorded in a former number of the Archives an example of its symmetrical and complete loss in connection with infantile paralysis.

Case II.—*Paralysis of anterior part of Deltoid from Peripheral Neuritis in the course of Ataxy after Syphilis.*

It would appear that the innervation of the anterior part of the deltoid is in a definite manner distinct from that of the rest of the muscle, for I have seen a second example of paralysis of this part only. In this second case the patient was a man of thirty-five, who had suffered from syphilis eight years previously, and in whom symptoms of ataxy were threatening. He had no patellar reflex, was quite blind in one eye, and complained of weakness in micturition.

The symptoms produced by this defect are peculiar. There is a sense of difficulty in lifting the arm from the side, and it is accomplished only by an effort and with muscular manœuvring. When once up, however, the arm can be kept there. It is difficult, or impossible, to bring the hand to the back of the head. Efforts at lifting the arm cause pain about the lower angle of the scapula and in the latissimus dorsi. The wasting of this part of the muscle could easily be felt. The rest of its substance, as in the previous case, appears to be in good nutrition.

Case III.—*Unexplained paralysis of the Deltoid Muscle in a man who was the subject of Syphilis.*

I once saw (almost by accident, the patient not being under my care) a remarkable case of paralysis of the deltoid. The subject was a healthy man a little past middle age, who had some subcutaneous knots and lumps in the mammary regions which were believed to be due to syphilis. When he was stripped I noticed that there was wasting of his left deltoid, so that the outline of the head of the bone was easily seen, and appeared to hang low. On asking him what had happened to his shoulder, he denied all knowledge of accident, and seemed to think there was nothing the matter with it. He could use his shoulder with certainly very remarkable facility, and lift it up almost as quickly and almost as high as the other. In lifting it, however, he clearly did most of the movement by the scapula. The wasted deltoid and fascia could be felt, but

on careful examination by several observers we could not make out that there was any action in any part of its fibres. I forgot to test sensation over the muscle. The muscle on the opposite side was in perfect condition, and the man had no other nervous symptoms.

I have made some little search amongst such works on the nervous system as are accessible to me without being able to find any cases similar to the preceding. I have indeed failed to find any detailed references to paralysis of the deltoid, alone, in connection with nerve causes. I do not know that the question of the possibility of paralysis of one lateral half of the muscle, alone, has ever been previously entertained, nor am I acquainted with any anatomical facts which would explain it. The only reference to this part of the subject which I have found is a statement of Duchenne, that in a case in which there was partial recovery of the deltoid after infantile paralysis, the anterior part recovered while the posterior remained atrophic. In this instance the atrophy of the deltoid was of four years' standing, the patient being a boy of seven and a half years. The other muscles of the upper limb were implicated as well as the deltoid. The anatomical facts in reference to the innervation and structure of the deltoid are so well known as scarcely to need recapitulation. It is supplied by the circumflex nerve, which comes off in common with the musculo-spiral, together with some other branches, from the posterior cord of the brachial plexus; and it supplies the teres minor as well as the deltoid, giving twigs also to other adjacent muscles. The deltoid muscle is of coarse structure, and its bundles are to some extent separated by bands of fibrous tissue. One of these does, in a sort of indistinct way, divide the muscle into two lateral halves. Although the muscle as a whole is concerned in elevating the upper limb, its clavicular and scapular portions work independently, and in mutual opposition, throwing the humerus forwards or backwards. This latter fact has no doubt an important meaning in reference to the occurrence of paralysis of one half of the muscle.

THE TREATMENT OF LUPUS BY KOCH'S FLUID.

In the last number of my Archives I briefly referred to two cases which had been under my care, and in which only negative results had been obtained from Koch's injection. Since then I have had (chiefly in connection with the post-graduate lectures at the Examination Hall) large opportunities for estimating the value of this method. Many cases were sent to these lectures for class demonstration, which had been treated by different surgeons. Amongst those to whom I was most indebted for opportunities of examining their results were Dr. Heron, Mr. Watson Cheyne, Mr. Waren Tay, Dr. Abraham, Mr. C. Macnamara, Dr. Hitchens, and many others. If I were now to sum up the result of my experience I fear it would be on the whole an unfavourable record. Not a few of the cases appeared to be little, if at all, improved. In some, I am bound to say, the results were, after long perseverance, excellent. Yet even of the best I cannot assert that I have seen a single one in which the disease was cured. The best results seemed to be obtained in cases in which there had been extensive inflammation with ulceration, &c., and without much of the true lupus growth. In these the attacks of inflammation induced by the injection appear to have had a very similar effect to that which we not infrequently witness after attacks of erysipelas. In the cases which most nearly approached to cures there always remained little islands of the brown apple-jelly deposit ready on the slightest provocation to set up new disease. In cases of what may be called quiet lupus, in which there is only the brown apple-jelly growth, without inflammation, I much doubt whether this treatment is of any avail.

DISEASES OF THE SKIN.

No. XLIII.—*On the Non-existence of Prurigo as a substantive disease.*

In my "Lectures on Certain Rare Skin Diseases" I have devoted considerable space to the consideration of the different forms of "Prurigo." Amongst other points I felt bound to express the opinion that the disease for which Hebra endeavoured to claim that name has no real existence. Since then I have, of course, continued to devote considerable attention to the subject, and may now briefly record my experience by stating that my note-books do not contain the record of a single case which would deserve the name of "Prurigo" as that of a substantive malady, or which would fit with the statements made by the distinguished Vienna Professor respecting it. In saying this I am well aware that I differ from many of my *confrères* for whose judgment I have the sincerest regard, and who are in the habit of occasionally making the diagnosis of "Hebra's Prurigo." I observe, however, with some satisfaction, that this term is falling into disuse, and that it is beginning to be generally acknowledged that if there is such a malady, it is met with in Vienna only. My inclination is not in the least towards controversy, and if the matter were one merely of verbal distinctions and of differences of custom in the use of words, I would most gladly let it rest. It is, however, one respecting which clinical accuracy is of very considerable importance, and on that plea I again recur to it.

No. XLIV.—*On Hereditary Irritability of Skin as the basis of what is known as Hebra's Prurigo.*

If I were to try to state clearly what, so far as I understand the matter, is the difference between the views of Hebra as

regards prurigo and those which I have myself ventured to entertain, it is mainly this. We both believe in a peculiarity of skin, born with the individual, which renders him especially liable to have it become irritable. Hebra holds that this peculiarity sometimes rises to such a height that without the intervention of any exciting cause, whether blood change, nerve disturbance, or external irritant, the skin may, as it were spontaneously, produce little itching papules, and further, that the tendency to produce these will begin in infancy and last till old age, with but little amelioration, either from change of climate or mode of life, or from drugs. My own view of the facts is rather that those born with pruriginous liabilities require, usually, some exciting cause or the development of their miseries. I hold also that the exciting causes may vary very much in nature, and that in connexion with each some modification in the result is witnessed. Thus the exanthemata, heat, cold, clothing, parasites, may each and all in turn, with many other agencies, be the effective causes of prurigo; the type of the evoked malady varying somewhat with each.

Thus in one sense the difference between us is but slight, for we are both obliged to fall back upon the hypothesis of a fundamental peculiarity in the individual as the remote cause of prurigo. For practical purposes, however, the difference is really considerable, for since under my theory much is attributed to exciting causes, many of which are susceptible of removal, much is to be hoped from careful attention in this direction. With Hebra, I quite admit that the peculiarity of skin which gives liability to pruriginous affections lasts through life and is in that sense incurable. But on the other hand, I think that such persistence is rarely made apparent unless the surroundings of the patient are exceptionally unfavourable; and further, I believe that the special mode of manifestation usually varies a good deal at different periods of life.

In the list of cases which I have given in a table appended to Lecture VI.,* there are many children who were uncured at the date of the last note. Most of these cases would

* See "Clinical Lectures," vol. i. page 90.

probably be classed by a disciple of the Vienna School as the early stage of the life-long form. But the question is, Will they remain uncured? and to this I have already given such reply as is possible. It is mainly this, that whilst we see scores of children with "infantile prurigo," few indeed are the adults in whom the condition has persisted. In the table to which I refer I have purposely retained the names of the children, thinking it possible that this may perhaps lead in the future to the identification of the patient by myself or others, and that thus important evidence as to the final result may be obtained. We want—in this subject as in so many others—complete cases, not mere fragments.*

No. XLV.—*Pruriginous Eczema much aggravated by scratching, and persisting through life.*

The case of a gentleman who consulted me in September, 1876, may serve to illustrate what I have been saying; but in truth such illustrations are very plentiful. Mr. W—— was aged 60, tall and rather pale. His father suffered from gout, but I saw no reason to connect this fact with the son's malady. When Mr. W—— first came he had a copious pustular eczema on his legs and thighs, with a slight diffuse eczematous state of his arms also. He said that he had been liable to it all his life, and he had in former years been under the treatment of the late Mr. Startin. On one occasion Mr. Startin relieved him quickly and very definitely by an ointment containing the nitric oxide and bisulphate of mercury.† Subsequently, however, this application failed to do any material good. On asking for detail as to his statement that he had had it all his life, he told me that

* For similar reasons I have in these ARCHIVES, whenever it could be done without risk of revealing anything which might be inconvenient or disagreeable, retained the patient's name. A rare example of disease often passes under the care of various observers, and its identification may not infrequently lead to very useful results. In all other cases I have carefully endeavoured to prevent identification.

† I subjoin Mr. Startin's prescription:— ℞. Hydr. Nitric-oxyd. gr. vj.; Hydr. Bisulph. gr. iv.; Cerat. Cereæ ʒj. It was to be applied twice a day. With this was an aperient, chalybeate mixture.

in boyhood and through middle life he had always had an itching, irritable skin. It was, however, never attended by any spots, and was often well for months together. The relapses, so far as he could remember, were not produced by changes in weather, nor did they occur specially in winter or summer. The first appearance of eruption occurred as a few scattered spots on his legs, which becoming aggravated by scratching about five years ago, passed into "sores." He described the itching as having been "fearful," and was well aware that he had aggravated the condition by scratching.

The conditions were symmetrical, both legs and both arms being affected. The face had never suffered. A brother and a sister had both suffered through life from irritable skin, but neither of them had ever had any breaking out. He considered himself a very bilious subject, but had never had gout.

I prescribed for him in September, 1876, a weak tar wash and a tar and mercury ointment, but he persevered with them through the winter and with but little benefit, and came to me again in April, 1877, rather worse than better. The eruption on the legs was now a suppurating eczema in irregular patches, with œdema and with scabs. There were many small scars of former ulcerations. On his arms were very large ill-defined areas of eczema in its more ordinary condition and without pustules or scabs. The skin was everywhere extremely pruriginous, and he was worn out by want of rest.

Although Mr. W—— remained for some years more or less under my observation, and with, of course, much temporary relief, yet I must admit that nothing approaching a cure resulted. One hindrance was his incurable addiction to scratching.

If I am asked why I refuse to recognize in such a case as this an example of prurigo of Hebra's type—an incurable disease lasting from childhood to old age—my reply is that we really have only an aggravated example of pruriginous eczema. To give it a new name is to dissociate it from its natural congeners. For one such case lasting through life, we have thousands almost exactly like it which have been cured in

childhood. Had this patient had more self-control and been more persevering in treatment, he too would have got well. The misfortune was that he had an irritable skin easily made to itch, and that when it did itch he would scratch. To say that he was the subject from the beginning of an incurable and lifelong malady is to divert the attention from the true chain of causation, and lead to remissness in the use of treatment.

No. XLVI.—*A Pruriginous Skin—Eruption of some years' standing aggravated by scratching—Keratosis of the palms from arsenic.*

Dr. S——, of G——, sent me a somewhat peculiar case, of which the following are the particulars. In writing to me, Dr. S—— stated that the eruption had been regarded as syphilitic, and that the patient had made his life miserable by dwelling upon this suspicion, and believing that the remains of the poison in his blood disqualified him from marriage, &c. It had even been feared that he would commit suicide. He had been under many physicians and some specialists, and by some the disease had been pronounced syphilis, and by others, as confidently, a different diagnosis had been given. The patient brought with him not only Dr. S——'s letter, but a very detailed account written by himself. This must be briefly summarized by stating that in 1883 he had a sore, from which nothing of the nature of secondary symptoms resulted. In the spring of 1884 he began to be troubled with itching on the knees and elbows, which was followed by soreness and itching on the scrotum and thighs. He was told that this was due to the hot climates in which he had lived. During the last three years he had taken mercury and arsenic internally during long periods, and in large doses.

It was a papular and erythematous eruption evidently much scratched. It was arranged symmetrically, and occurred chiefly on the borders of the axillæ, on the buttocks, legs, and abdomen. Everywhere it had left minute white scars.

It affected the face slightly, also the scalp and the front surfaces of the arms. There was none in the fronts of wrists, and none between the fingers.

At first sight of the eruption on the sides of armpits and buttocks, I felt sure that it was an uncured scabies of very long duration, but I could find no burrows, and the history negatived this view.

The palms showed a condition of diffuse keratosis with little hard corns, which he was in the habit of picking out with his nails. I thought that this was probably due to arsenic, and found on referring to his prescriptions that he had taken arsenic for years. "Nearly every doctor whom I have consulted gave me arsenic in some form."

Before this special eruption he had been liable to common acne, and used to perspire freely. Mercury had never done him any good. He had often been kept awake by the itching. "You might as well tell the sun to stand still as tell me not to scratch." I mentioned the term "Shoemaker's buttocks" to him, and he at once added, "Well, do you know when I sit in a tramcar the movement makes the buttocks itch till I can scarcely sit still."

As regards the keratosis of his hands, he said that his finger-ends were at one time numb,—a remark which confirms the suspicion that their present condition has been induced by arsenic (see ARCHIVES, vol. ii. page 196). I formed the clear opinion that the eruption was not syphilitic, and that in all probability he had never had syphilis. It was a form of lichenoid eczema with extreme pruriginous tendency. The susceptibility to local influences, friction of clothes, scratching, irritation from his seat, &c., had been most marked. The patient lacked self-control, and had scratched severely. The state of his palms was, I believe, the result of the drug which had been used for his cure, —that is, it was arsenical keratosis. Confirmatory of this suggestion was the fact that he appeared to have suffered at one time from arsenical numbness.

No. XLVII.—"*Hebra's Prurigo*" *in early stage—Pruriginous General Eczema in a young child, as yet uncured.*

The case of a little girl named Violet C—— is of much interest in reference to this subject. It was a very good example of the first period of what many authorities call "Hebra's Prurigo." In essential features, however, I must contend that it was eczema. As to whether it will or will not be a life-long disease will depend upon the care and attention that is given to the treatment. There is no question that it will prove a great trial to the perseverance of the mother. When I first saw the child she was a little more than two years old, of rather dark complexion, and in good general health. She had been continuously under treatment since the age of four months. Her body and limbs were covered with a scratched lichenoid eruption, which was especially severe across the loins. On account of this eruption the child had never been vaccinated. It was believed that she had never had chicken-pox. The eruption affected the hands as well as the forearms. It did not affect the face or scalp to any great extent when I saw it, but I was told that it had begun on the face. Now as to its eczematous character we may note that it began at the age, and on the part, at which infantile eczema is most common. Further, it affected the lips and mouth, the popliteal spaces and fronts of elbows, and on all these parts it was characteristic eczema. It was exceedingly pruriginous, the child was constantly tearing the skin, and no doubt its characters had been much modified by scratching. There was no history of skin diseases in the family. The mother told me that both she and the child had exceedingly irritable skins, and if attacked by fleas, suffered terribly. The child had at one time been nearly cured by a three weeks' residence at the sea-side; and at another time had been much better at Reigate. It did not appear that this was in reference to the water used in washing, since they always used rainwater at home. The child had been brought up after the first six weeks by hand. I advised that it should abstain from milk, and as much as possible from sugar; should take

green vegetables and potatoes freely. The prescription consisted of a tar lotion to be used as a bath and as a wash; and of medicine containing the bicarbonate of potash and bromide of sodium.

No. XLVIII.—*Pruriginous Eczema in an infant, lasting, uncured, into adult life.*

A case which was shown to me by my friend Dr. P—— well illustrated the state into which this child will eventually pass, unless we succeed in curing it. Dr. P——'s patient was a young man of 22 or 23, and was shown me as a good example of Hebra's Prurigo. He was covered from head to foot by a pruriginous eczema. It was worst in the popliteal spaces, and on the fronts of the upper limbs. The history was that it had begun in infancy on the scalp, and as far as we could ascertain, had then exhibited all the peculiarities of infantile eczema.

No. XLIX.—*Pruriginous Eczema in an adult—Much scratching.*

I have rarely seen a case which, in its external features, more closely resembled what is called Hebra's prurigo than did that of Mr. A——. He was an intelligent Scotchman, and head keeper to Lord D——, and was sent up from a northern county for a state of skin which had proved intractable under a great variety of medication. He was a man of strong will, and not over equable temper; and had been a most resolute scratcher. On entering my room he proceeded at once to strip himself in order to show his distressing condition. Although well tanned by weather on his face, his skin under his clothes was far darker, owing to the pigmentation caused in part perhaps by remedies, but chiefly by incessant scratching. On many parts the skin was thickened and indurated, this being especially the case on his legs, arms, and in the cleft of the nates. On his abdomen and buttocks there were a number of hard chronic pustules, dusky in colour, and varying in size from an acne spot to a small

furuncle. On his buttock was one positive boil; but for the most part these furunculoid indurations ended with very slight suppuration, and without any core. Mr. A—— said that nothing he had tried materially alleviated the itching, and that often he did not sleep till daylight, and for months together he did not get more than three hours' sleep. Under these conditions he had somewhat lost flesh, but was, in the main, still a vigorous man. Some other points about his skin require to be mentioned; on the fronts of his wrists there were groups of little papules about as big as pins' heads, which were arranged in transverse lines, and which were becoming polished on their tops, reminding one of lichen ruber. On his elbow tips were large oval scaly patches, exactly like psoriasis. In the upper part of the cleft of the nates the skin was thick, hard, dry, and scaly, again resembling a condition not unfrequently met with in this part in psoriasis. On other parts the morbid changes were diffused, and a general condition of dryness and scaliness with pustules, papules, and little fissures made up the *tout ensemble*. The face and neck were almost free.

Having thus sketched the features of the disease, and shown how large a part the pruriginous element took in it, let us now examine as to the history. Mr. A—— was not aware that there was any special tendency to skin diseases in his family; he had nine children, and none of them had suffered from eczema. He assured me that up to the age of 20 his skin had never been irritable. About that time he had a severe attack of itch, which was prevalent in the village. He recovered from it, but had frequently remarked to his wife that his skin had never been right since; by which he seemed to mean that it had been discoloured, and more liable to itch. In early life he had suffered from acne on his shoulders, which had left many scars, and had at various times been subject to boils. The severely pruriginous state I have described had not fully developed itself until eighteen months before I saw him, and it then began as a sort of dry eczema on the leg. From this leg it spread up the thigh, then affected the other leg, and then the whole body. It had been getting steadily worse and worse. In former years Mr. A—— had drunk

spirits in excess ; but he had always, as a gamekeeper, lived a healthy out-of-door life. Although he had been told that his liver had been enlarged, and had once suffered, eight years ago, from pleurisy, there was no reason to think that he had materially damaged his tissues.

If now we proceed to analyze the case, as regards its various elements of causation, we may probably in the first place recognize a proclivity to acne and boils—a furunculoid predisposition—which had existed through life. Next we have a severe and prolonged attack of general scabies, which left the skin hyper-æsthetic and irritable.

Inattention to the proper means of cure and resolute and persistent scratching must rank as the next factor ; and lastly, but of great importance, the infective qualities of all eczema. The patch of eczema which occurred in the leg probably infected the rest of the skin. Thus we recognize a chain of partnership causation, producing complicated phenomena. This is, I would submit, a very different thing from giving the disease a definite and specialized name. That the case although presenting features of similarity yet did not conform to the type of Hebra's Prurigo, is obvious. It had not begun in infancy, nor even in early life.

I may briefly remark that I have never yet seen in advanced life an example of a severely pruriginous skin in which the history went back to infancy.

No. L.—*Recurring inflammation of the hands in a healthy boy—Vesicular and bullous eruption, with tendency to form pus — Usual duration of attacks a fortnight — Present attack more severe — Extension to trunk—No benefit under arsenic, and cure under antimony.*

When we succeed in the formation of a natural classification of diseases, a separate family must be formed of those which tend to get well of themselves and after an interval to recur. Whether we shall feel justified in classing all such as

in essence "catarrhal" * may be open to doubt, but most clearly they differ from all others.

It is obvious that in such cases as the following, the proneness to recurrence without obvious cause is by far their most important clinical feature, and with it we may place the tendency to spontaneous, or almost spontaneous, disappearance. These features separate them widely from all forms of eczema, and also from all common types of pemphigus. On the other hand, they ally them closely with the conditions which I have described under the name of cheiro-pompholyx. The present case indeed only differs from typical examples of the latter malady in the great excess of inflammation and the tendency of the inflammatory products to become purulent. These features may have had something to do with the early age of the patient: for all the cases of cheiro-pompholyx which I have as yet seen have occurred in adults. The fact that the boy was always noticed to be out of health a few days before the eruption appeared is quite in accordance with what is noticed in cheiro-pompholyx.

There are other forms of dermatitis which are liable to periodic recurrence such as noted in this case. The New Sydenham Society's Atlas contains a beautiful portrait of a case of "erythema marginatum" in a young and healthy boy, in whom the history was that it recurred periodically and got well almost spontaneously. It was a severe eruption, and was attended and preceded by considerable disturbance of health. In that case we found that arsenic not only rapidly cured the disease, but definitely prevented its recurrence. For years afterwards the boy's mother used to keep her arsenic medicine in the house, and if the boy became fretful or languid it was at once had recourse to. Under this plan no severe attacks were ever developed, although there were often slight threatenings. I thought it not at all improbable that arsenic might in a like manner control the attacks of inflammation of the hands in the case which is about to be described. In this expectation, however, I was disappointed.

The subject of my present case was a boy aged about eight

* For explanation of the meaning which I give to the term "catarrhal," see ARCHIVES, vol. i. pp. 307–8.

years, who was brought to me in May last, when I took the following notes :—

The present attack is the worst that he has ever had. He never before had any spots on his face. He has often had slight or abortive attacks. The last severe one was in the autumn. Season has not appeared to exercise any influence. The attacks usually occur two or three times a year. The first definite attack of "blisters on the hands" was at Shanklin when he was a year and six months old.

Before an attack occurs he is usually languid, and complains of his legs aching. No local irritation has ever been observed as a cause. He is sometimes bilious, but in the main has good health. He is a very free sweater. He plays about with other boys in hot weather, and does not suffer from his hands excepting that he gets "heat spots" on them. His father was liable to eczema when a child, but not badly.

The conditions presented by the hands when this boy came under my care on May 1st are tolerably well shown in a sketch which was executed for me by Mr. Burgess. It shows the fingers swollen and excoriated, and the backs of the hands covered with small bullæ, most of which contained opaque greenish pus. On the wrists and lower parts of forearms there were some undeveloped erythematous patches with more or less of tendency to bullous effusion. The epidermis was loosened in several parts of the palm. On the day before the sketch was taken I had prescribed arsenic, and the disease was already apparently on the decline. A week later I was able to make the following note :—

Master B—— (May 7, 1890) ; his hands are rapidly getting well. The bullæ on the backs of hands have almost all dried up, and the general inflammation is much less. There is still a little sore at one corner of his mouth. He is reported to be better in himself, but still easily tired. His appetite is returning. The tongue is cleaning. It has been covered with a thick creamy fur.

My next note records a relapse and an extension of the disease.

May 16th.—He has been taking arsenic and bark, and using a boracic ointment. He has not regained appetite, and is, on

the whole, worse. The eruption has spread up his arms, upon his face, and has appeared on his knees. He has frequent micturition, and sleeps badly.

The eruption spreads as a pustular and vesicating lichenoid eczema. His hands are still excoriated all over. On his face it is pruriginous. He has had much headache.

At this date, as the eruption, although better on the parts on which it began, was still extending, I decided to change the treatment. The arsenic was abandoned, and tartarised antimony substituted in doses of one-sixteenth of a grain three times a day. A week later I was much pleased with his improvement.

May 22*nd.*—Under the antimonial mixture he is much better, and has a very good appetite. Hands much better, and face, although thickly crusted, less inflamed. Many spots in front of right knee, but all less inflamed. His feet, which were swollen, but without actual eczema, are better. The eruption is practically dead. He had felt much out of sorts, but under the antimony feels quite well.

After this last note I believe he soon got well.

No. LI.—*A case in which Leucoderma has become almost universal, and the scalp hair has become white.*

Mrs. J—— (formerly Miss R——) is an example of leucodermic changes having spread over the whole surface. They began at the age of 8 by white patches on the hands, neck, and face. Now, at the age of 28, she is blanched over the entire surface, excepting some patches on her body. (These I did not inspect.) Her hair is almost wholly white. Here and there, however, are some dark tufts, especially on the occiput. Her eyebrows and eyelashes have not blanched, but are still of a moderately dark-brown colour. The whiteness of her face and neck is very striking. She was originally of a dark complexion, and her mother is very dark. Her hands are quite white. During summer, when exposed, she does not tan at all, but the skin of the neck may become red and even sore. She has rather florid cheeks, but when suffering from

headache she becomes of marble whiteness over the whole face.

In girlhood I attended her for ringworm, and it is believed that it is on the parts then affected that the dark hairs now grow.

Mrs. J—— has been under my observation, more or less, most of her life. I believe that the leucodermic changes are still advancing on the body, but her face, neck, and hands have been in their present condition for some years past.

No. LII.—*Coloured Perspiration.*

There is a curious symptom which I have not seen noticed by other writers, which consists in coloured perspiration from the axillæ. Sometimes it is coincident with coloured secretion from the sebaceous glands—indeed I am not sure it is not a fact that the colour is always derived from sebaceous secretion, and not from the sweat itself; probably the sweat dissolves the sebum. In one case, in a gouty gentleman of about fifty-five years of age, little beads of an orange colour used to form on the hairs of his axillæ, and would adhere closely to them. When he perspired much—and he used to break into perspiration very easily—the moisture stained his linen. He was liable also to excoriate between his toes from perspiration. In another case a surgeon, aged fifty-four, again the subject of gout, was very much annoyed in warm weather by perspiration in his arm-pits, which stained his linen red. There was no proof in this case of any excess of sebaceous secretion.

No. LIII.—*A very peculiar form of Clustered Comedones—Large groups placed symmetrically on the thighs.*

A very curious case of comedones in groups, or local seborrhœa, was brought under my notice in the person of an elderly lady, Mrs. C——. It should be stated in the first place that Mrs. C—— had been through life the subject of a dry skin; she said that she had never been able to perspire, and that in early life when heated her skin would flush and

burn intolerably. As years had advanced she had suffered less inconvenience from this, but the skin still remained not only free from tendency to sweat, but also without any liability to become greasy. She had for years been accustomed to sponge herself with a weak solution of glycerine in rose-water. This she said had suited her better than any other application, and had the effect of preventing the skin feeling dry and harsh. Her skin was indeed, without being actually scaly, in a slight condition of xerodermia or ichthyosis minima.

Quite recently Mrs. C—— had suffered from a severe hepatic illness (probably gall-stone). The condition for which she consulted me was what she called patches of eczema on her thighs. These had troubled her for about a year. I found that the patches were not in the least eczematous, but that they consisted of groups of plugged sebaceous follicles. There were two patches placed quite symmetrically on the outer part of each thigh, a little below the great trochanter. Each was about as large as an outspread hand, and shaded off at its margins gradually into healthy skin. The patches consisted of a great number of hardened and polished plugs of sebum. Some of these were not larger than pins' heads, but many were as big as small shots. The largest were in the middle of the patches, and towards the margins the conditions gradually diminished until the gland orifices could only just be detected as brownish dots. There was not the least inflammation of the intervening skin, but the spots were so closely placed that they were almost confluent; in fact in some instances two or three seemed to have coalesced. In order to convince Mrs. C—— that they could be removed, I made her lie down on the couch, and proceeded with an acne scoop to extract the plugs. After about a quarter of an hour's diligent work I had removed probably about a hundred, and the skin was left covered with a number of little holes which were quite dry. The plugs did not go any depth into the skin, and in some instances, specially near the middle of the patch, they were almost globular. Towards its margins they were longer, and more like "the grub" from a common acne comedone. The longest, however, was not more than one-

eighth of an inch. They were all absolutely dry, almost like bees-wax. The process seemed to be one in which the plugs, while they increased in size, were gradually extruded from the follicles. I have no doubt that they would in the end have dropped out, although even in their dryest condition they still adhered very firmly.

From the exact symmetry of the condition, and from the entire absence of spots on other parts of the skin, it did not seem probable that any source of parasitic contagion would be found. On all other parts, as already explained, the sebaceous glands were remarkably free from tendency to enlargement. I examined the little plugs after removal, found them exceedingly hard, but splitting under pressure into shiny scales. They dissolved in benzolene with great difficulty. I did not succeed in detecting any parasite either animal or vegetable.

No. LIV.—*Two cases illustrating Psoriasis Eczema of the hands.*

I wish to contrast two cases of disease of the skin of the hand which are at present under my care, in order to illustrate, among other things, some of the differences which are sometimes observed in reference to difference of age. In the first case a girl of 17 is the subject of a sort of mixed psoriasis-eczema of the hands. It affects chiefly the backs of her hands, being specially severe around the roots of the nails and in the cleft between the thumb and forefinger. Its arrangement and characters are shown in a sketch which I possess. Although it is now for the most part a scaly eruption, and unattended by any moist exudation, the history given by the girl's mother seems to show that it was in the beginning an intertrigo-eczema, for in early childhood it affected the popliteal spaces and the axillæ. These parts are now quite well, and the hands and feet alone are affected. On the latter it has now persisted for many years. It is to be specially noted that the palmar aspects of both hands and feet are perfectly sound. The pulps of the fingers are smooth and soft, but around the roots of all

the nails there is a border of inflamed skin with scale-crust. The nails themselves are pitted and furrowed on their surfaces, but not thickened. In the senile case about to be mentioned the reverse of these conditions is observed. The palms suffer and the backs of the hands are free. The finger-pulps are dry and cracked, but the nails wholly escape. In the case of the girl some little approach to what I have named sycosis unguium is seen, although it is by no means a well-marked example of that malady.

The senile patient is a lady named N——. She is sixty-seven years of age, stout, and although she does not know of any gouty history in her family, she has herself suffered from an inflammation of the great toe joint which she describes as very much like gout. Her skin disease consists in a diffused dry inflammation with cracking and peeling of the whole palms, and especially of the finger-ends. She has had it for two years, and it is slowly advancing on the fronts of the wrists. The soles of the feet are affected symmetrically just under the insteps. Here again the patches are of the same character, the skin becomes dry and peeling, with cracks. The affected parts burn and tingle, and the condition of her finger-pulps is such that she can scarcely use her hands. The nails are very slightly affected, and only where the inflammation extends from the finger pulp under their free borders. There is no pitting of their surfaces as in the other case. It will be seen that there is in this instance a certain amount of evidence in favour of the gouty origin of the malady. The urine deposits a considerable quantity of uric acid, and the patient has suffered from attacks which were probably mild gout. There is no history of skin disease in early life. Her case may I think be taken as a fairly typical one of a form of psoriasis palmaris met with now and then as a distinctly senile disease, and which is very rarely seen in early life.

No. LV.—*Two cases of Chronic Skin Disease (unnamed)—A Desquamative Dermatitis persisting without any failure of health for many years.*

I have at present under care two patients in whom certain

skin phenomena of long persistence are almost exactly alike, and, so far as my acquaintance with nosology goes, very difficult to name. Both my patients are men, and both apparently in robust health, and neither of them would care anything about his skin disease were it not that it is very conspicuous and entirely prevents him from bathing in public. In one case the patient has the additional source of disquietude and anxiety in that he believes his affection to be syphilitic; but in the other this suspicion is not present. It may be most convenient to take my second case first. Mr. Q—— is an Irish lawyer, aged 30, whom I have seen several times during the last fifteen months. The skin disease began twelve years ago, that is at the age of eighteen, and at that time he had never had any venereal affection. Since then he has had an "excoriation," but it was not followed by any indications of constitutional disease. His skin disease at present consists in large, erythematous, slightly desquamative areas on his limbs and trunk. They are so abundant on his thighs and legs that almost the whole surface is covered. On the sides of his abdomen, and on the fronts of his arms, there are a few large but quite discrete patches, there being none on his back, or front of chest, &c. The whole of his scalp is involved, but is only very slightly affected, the condition being one of diffuse pityriasis. Mr. Q——, who is an intelligent and highly educated man, tells me that the affection began on the front of one forearm, and that he then considered it an erythema. Two years later, in the summer of 1879, he had a general peeling of the whole surface. At this time, though he did not feel in any way ill, he was "so branny all over" that the scales used to shake off when he undressed, and would collect in his bed. One might suppose that he was then the subject of a pityriasis rubra, but the affection was not a severe one, and disappeared after a few months without any very special treatment. When it went away his eruption lapsed into its present condition, and so it has persisted ever since, being sometimes better and sometimes worse. He has not been able to appreciate any very definite increase from weather, but thinks that it is rather worse in winter. At other times it gives him no material

inconvenience; but in frosty weather he says his thighs are apt "to get aired,"—by which he means, I think, that there is more or less tendency to chapping. Excepting a certain degree of itching of the scalp at night, he has no irritation. He has tried a great deal of treatment and has taken a good deal of arsenic; and has never experienced any material improvement from any drug. It is to be understood that in its present stage the eruption only desquamates slightly. Some of the patches are abruptly defined, but on many parts of his thighs they have coalesced and the condition has become diffused.

If I were to describe the case of Captain S——, I should have to use precisely the same terms which I have employed for Mr. Q——. The same parts are affected and the same appearances have been produced, with these differences, that he has no pityriasis of the scalp, and at present there are some lichen spots over the whole front of his chest. I am describing his eruption as it was on December 31, 1888. It began in 1874, and has never left him completely during the whole of the fourteen years. There is a very doubtful history of remote syphilis; but he is married and has four healthy children, and his eruption does not look like any syphilide with which I am acquainted. I saw him first in May, 1874, and then assured him that it was not syphilis and ordered him only a tar wash. In August, 1874, as the eruption still persisted, I ordered arsenic. In May, 1888, my diagnosis appears to have wavered, for I find that I then ordered him mercury. I may add that in 1876 he saw Mr. Berkeley Hill, who told him that he did not think his eruption was syphilitic. The eruption had in the first instance begun as coffee-stains on his ankles, and had steadily advanced up his legs.

In both these cases the eruption was quite symmetrical. I may ask attention to the fact that in neither has the prolonged use of arsenic done any good. In this point, as in several others, we have a marked difference from common psoriasis.

DISEASES OF THE NERVOUS SYSTEM.

No. XXVIII.—*Complete Deafness, following an injury to the head—Loss of smell and taste.*

But very few cases are on record which may give us help in the prognosis of such as the following. The all-important question for the patient and his friends is, will the total abolition of a special sense, which at present exists, be permanent? Cases of deafness in one ear from fracture of the base of the skull crossing the petrous bone are not uncommon, and in them I fear the condition is usually lasting. The peculiarity of the following case consists in the fact, that probably the bone lesion is symmetrical.

A young gentleman, of about twenty-four, who had been attending a social dinner at one of our metropolitan hotels, in going down the stairs caught his foot in the carpet, and fell. It was not known exactly how he fell, but it was probable that the chief injury was from striking the back of his head on the edge of the stone step. He was found by his friends, who were following almost immediately after him, at the bottom of a short flight of steps, face forwards; but his face was not in the least bruised, whilst a line across his occiput was swollen, and it continued afterwards for some days very tender. It was quite certain that he had not been pitched forward on to his vertex. He was quite unconscious when found, and was in the same condition when Dr. M—— reached him about half an hour later. He was then bleeding from the nose, but not very profusely. There had been no hæmorrhage whatever from either ear. During the next twenty-four hours he gradually regained consciousness, and when that was

attained it was found that he was absolutely deaf. Subsequently it was ascertained that he had lost smell also, and taste to a certain extent. There was no facial paralysis, nor any trouble as regards the bladder or bowels. During the two days immediately following the accident he was extremely thirsty, and insisted on drinking quantities of water, which he always speedily returned by vomiting, and usually with some traces of blood. During this period he was not allowed to take any food by the mouth. During the second day he had two attacks of convulsion, during which, the nurse states, both sides of his face and all his limbs twitched violently. A condition of extreme restlessness characterized the first few days. He liked to bury his face in the pillow, and was never quiet for more than a minute or two at a time. He complained of severe headache.

When I saw Mr. W——, in consultation with Dr. M——, on the fourteenth day, most of the symptoms had passed away. He was sitting in his chair, reading the newspaper, and looking quite well. The distressing fact which remained was that he was still absolutely deaf. It was believed that he had never heard anything whatever since the accident, excepting possibly on one occasion a loud cough, but even this he afterwards denied. I procured a loud-sounding bell, and rang it close to each ear, but he assured us that he heard nothing. He had regained his taste to a considerable extent, and probably his smell also, but not equally. He did not now complain of any headache, and could take food well. He denied that he felt giddy; but he walked with a reeling gait, as if he were so. The chief question of course concerned prognosis; was it likely that he would regain his hearing? Dr. M—— and I agreed in the diagnosis, that he had in all probability sustained a fracture of the base of the skull; which, beginning at the occiput, had passed forwards through the petrous portions of both temporals, and had ended in the ethmoids. It was a remarkable fact that the portio dura, on each side, had entirely escaped. In all probability, both internal ears were filled with blood.

Examination of the membranes showed the left drum very much drawn in, with swelling of the meatus near to it; the right showed no very definite change. There was no sign of

perforation in either, and, as already said, there had been no bleeding from either.*

No. XXIX.—*Complete Paraplegia still present six months after a Dislocation of the Spine.*

I saw at St. Thomas's Home, with Dr. Edmunds, a case of much interest in reference to the symptoms of crushing of the spinal cord. The patient, a gentleman of thirty-five, stood six feet two, and had consequently a very long back. In consequence of the slipping of some earth from the top of an old fortification, he had fallen with the earth a height which was subsequently ascertained to be nearly seventy feet. He was stunned for the time, and nothing definite is known as to the precise position in which his body had come to the ground. The conditions about to be described, however, make it almost certain that he was forcibly doubled up with the head between the thighs. As soon as he had regained consciousness it was ascertained that his lower extremities were completely paralyzed, and that he had no sensation below the level of his navel. The accident occurred in Burmah, in June, 1890, and our consultation on his case took place in December of the same year, a few days after his arrival in England.

The indications, when I saw the patient, were quite definitely those of a displacement between the tenth and eleventh dorsal vertebræ. At this position there was an irregularity, the spinous processes of the eleventh and twelfth very decidedly projecting backwards. The displacement was not great, but it was definite, and it could only have been produced, I think, by some crushing of the body of the eleventh. The line of the spinal column was quite straight, as regards lateral displacement; and no material

* I have never demonstrated in the dead-house a circular fracture of the base, which had begun at the occiput. The bleeding from the nose which occurred in this case, and the entire loss of smell, make it probable that the fracture had passed forward into the ethmoids, and on both sides. This, however, is not certain, for the loss of smell may have been due to contusion of the olfactory bulbs. In one case of circular fracture of the base, with absolute deafness, which I proved post-mortem, the lesion was caused by the man having fallen head foremost on to his vertex. See Pathological Society's Transactions.

posterior projection would have been noticed if the patient had been standing up. It was appreciable on manipulation, but scarcely so to the eye. On inquiry as to the history of the symptoms immediately after the accident, I found that there had been retention of urine, which was relieved by the catheter on the second day. The catheter was employed for some days afterwards, and then the bladder recovered some of its tone, and incontinence resulted. There had been from the first incontinence of fæces whenever the bowels were relaxed. I inquired as to priapism, seeing that the injury was just in the position likely to have produced it. Our patient said that he was not aware that it had occurred; but as the parts had been throughout completely devoid of sensation, he did not know much about it. He said that he had suffered much from erotic dreams during a few weeks after the accident. He believed that he had been "off his head and delirious" for some little time, a week or two after the accident; although he had been perfectly conscious in the first instance. There had been large bedsores on his sacrum and heels, but they were now almost cured.

Our consultation (which took place on December 31, 1890, just six months after the accident) chiefly concerned the questions as to prognosis and treatment. Was it likely that the case would end fatally? was it possible that the use of the legs should ever be regained? and lastly, was it desirable that any operation should be performed? Taking the last first, I felt no hesitation in discountenancing the idea of operative interference. The displacement of the vertebræ was not sufficient to make it at all probable that any compression of the cord by the laminæ was still existing. Probably the cord had been crushed at the time when the body was most bent, and the bones had been almost completely restored to position when the trunk was straightened. This view was quite in accord with that entertained by Dr. Edmunds previous to our meeting. As regards prognosis in reference to probable prolongation of life, the patient having regained good bodily health and his bedsores being almost healed, we had chiefly to think of the possible consequences of disease of the bladder and kidneys. He

had had cystitis, and was not yet wholly free from it. The bladder, however, was now accustomed to relieve itself, and the use of the catheter was not necessary excepting for washing out. Thus although it was impossible to ignore the danger of secondary disease of the urinary organs, it did not appear to be either immediate or great. With care the patient might live on for years. We next came to the question of the probability of repair, and in order to answer this we carefully examined the history as to improvement and the facts as to his present condition. Although six months had elapsed, it could not be said that there was any return whatever of sensation or motion in the paraplegic parts. He could not accomplish the slightest movement, nor could he feel in the least. The boundary of the loss of sensation was a line curving from behind forwards to a little below the umbilicus.

The only points in which there was any history of improvement were, that he was now free from the pain which he had first experienced; that he had much less of the sensation of girdle tightness; and that his lower limbs did not jump as much as they used to do. Dr. Edmunds had observed, respecting his reflexes, that whilst there was no movement produced by striking his ligamentum patellæ, a response could always be obtained by hitting the shin-bone or the patella itself. The movement produced was, however, not a jerk forwards, but a flexion at the knee by the hamstring muscles. No irritation to the skin or soft parts, on any part of the lower extremities below the knee, evoked the slightest movement. The latter occurred only when the bones were struck. On the thighs, tickling of the skin at once produced slight flexion at the knee. In the earlier periods of the case the patient said that he had been much troubled by jumping of the limbs, but it had been less of late. This entire absence of any return of functions and the completeness of their abolition were very unfavourable symptoms as regards the probability of recovery.

In a case which I mentioned in my presidential address at the Neurological Society, a gentleman who had been eighteen

months confined to his bed, for an injury to the spine attended with great and conspicuous displacement of the bones, recovered so far as to be able to walk about. His permanent inconveniences were incontinence of urine and fæces, with a liability to attacks of cystitis at intervals. He has, however, for some years been engaged in the active pursuits of life, and has even recently married. His case differed, however, from the one given above, in that the injury was to the lumbar spine, and that the paraplegia was never absolute.

No. XXX.—*The influence of Arsenic upon the Nervous System.*

I do not think that there can be any reasonable doubt that arsenic does in a remarkable manner influence the vaso-motor system, and produce alterations in the supply of blood. Thus, it may cure the erythema of lupus erythematosus, but it may cause flushing of the face and eyes, and burning sensations in the hands and feet, which are the equivalents of flushing. The symptom of red eyes and pricking of the conjunctiva as an indication of the influence of arsenic on the system, has long been known. It is an intermittent condition which comes and goes. In some cases there is pricking only with a pale condition of conjunctiva, and a sensation as if sand were in the eye. In many, the eyelids are puffy. In all cases, reading and all use of the eyes is more or less painful, especially by artificial light.

These eye symptoms are by no means the whole of what arsenic may do in disturbing the capillary circulation. It may cause a very marked tendency to flushing of the whole face. The flushings will occur in connection with exciting causes such as usually produce them, as after taking food, or on coming out of the cold air into a warm room. At the same time there may be evidences of disturbance in the extremities, the hands and feet may tingle and burn, and may become very tender. In rare instances little horny warts may form on the fingers, or the epidermis in the palms may first thicken in patches and subsequently break up.

These remarks are illustrated by the following case:—

Miss H—— left off the arsenic last summer, but took it again last Christmas, in doses of seven minims three times a day regularly. These doses have been continued for three full months. She now complains much that her eyes prick, and that she is liable to most painful flushings of the face. These flushings occur chiefly after meals. Her sister says that her face becomes almost purple.

She has had chilblains all through the winter. These she often had before, but not quite so badly. Her hands and feet feel tender, and swell. On both hands and feet a number of little corns or horny warts have formed. These are on the fingers, not in the palms. She is liable occasionally to "pins and needles" in the limbs. Reading by artificial light is painful. Her appetite is good, and she feels strong and well. Menstruation regular but painful.

Her lupus patches have got almost well, that in the nose having, however, left a keloid scar.

No. XXXI. — *On the form of Paralysis which attends Spina-bifida in cases in which the patients survive.*

Two examples of survival with spina-bifida have come under my observation recently. One is a child named Young, whom I have seen at times from infancy; the other a girl of sixteen, brought to me for the first time by Mr. Fitzroy Benham. They are so closely similar that it may be convenient to contrast them.

In Mr. Young's child the feet have gradually turned in until now there is an almost complete condition of varus. She has recently taught herself to walk, but treads wholly on the outer border of the foot. Her legs are exceedingly thin, and all the muscles weak, but it is very difficult to tell which sets are most affected. She walks with great trouble and much uncertainty. Her mother says that she is much improved as regards retaining her urine and feces, but still has incontinence of both at times.

Her progress would encourage the belief that the nerves affected by spina-bifida may to a certain extent regain their function. The same lesson is taught by the next case also, for in it the patient now but rarely suffers from incontinence of urine in the daytime, and at first asserted that she never happened accidents with her bowels.

The second case was brought to me by Mr. Fitzroy Benham from the Queen's Jubilee Hospital, and was of yet greater interest, for the patient could walk well. She was a well-grown girl of sixteen. The spina-bifida, as in the preceding case, was in the lower sacral region, and not quite in the middle line. In both it lay rather to the left. It was large, and freely fluctuating, almost as big as an infant's head. It was reported to have got larger of late, but it had caused no inconvenience excepting from its bulk. The girl had very slender but shapely limbs, and could walk well. I could not discover any tendency to talipes. It was admitted that there was a liability to incontinence of urine, but it was asserted that there was no trouble with the bowels. On examination with the finger, however, I found that the anal sphincter was quite relaxed; in fact I could not appreciate any action whatever, and easily passed two fingers side by side. The bowel was full of hard, dry feces, the condition of which was the explanation of their not escaping.

Mr. Benham had on three occasions during the last three months tapped the tumour, drawing off many ounces of serum. Our consultation was as to whether any radical operation was required. I found Mr. Benham averse to Morton's injection plan, alleging that he had repeatedly known ill results and even death from it. I opposed any other kind of operation. My argument was that in addition to the danger, it was impossible that such an operation as excision of the sac could do any good. It could not possibly benefit the sphincter-paralysis, and it was very possible that it might damage the nerves still more, and make the sphincters weaker, or even injure the lower extremities. I urged that in these cases there was usually no aggressive tendency. The tumours did not increase, and the innervation of the

regions involved improved rather than otherwise. The permanent inconvenience is the bulk of the tumour, and it is not worth encountering much risk merely to get rid of this.

I have on former occasions published not a few cases of spina-bifida. In several which I have seen patients have lived to adult age with considerable tumours, and no paralysis whatever. In one such, a woman had a family of children. In others, the feet escaped, but the sphincters were defective. In no case have I known the sphincters escape if there was any defect in the feet. I am not myself responsible for the death of any patient excepting quite young infants, who were treated by paracentesis only; but I am cognizant of several in patients of more advanced years, who might have lived if let alone.

DOCTRINAL PATHOLOGY.

(*Continued from page* 212.)

I HAVE elsewhere adverted to three remarkable features which are not unfrequently observed in Melanosis. The first of these is that the primary growth may never develop at all; the second, that the gland growth often attains a very large size; and the third that there is frequently a remarkable tendency to multiplicity of reproduction, amounting to almost universal dissemination throughout the body. In cases in which the original tumour remains small, and in which there has been no reproduction in the glands, the ordinary laws of population-increase may probably be called in to explain this last peculiarity. The Greeks colonized the whole of the Mediterranean, but nowhere developed any large city. The Romans, sparing in colonization, grew into an enormous home state. It is clear that the laws of population would prevent any nation from accomplishing both these ends at the same time; you cannot both scatter and keep. So in new growths, the amount of specialized material which the body can afford is restricted within certain limits. If the primary growth increases quickly, it does not at the same time give material for the infection of other parts; and if a gland-mass grows largely, it probably to some extent prevents the tendency to multiple manifestations elsewhere.

The prevalence of Diphtheria in the wards of several of our London Hospitals during the last few months has occasioned great anxiety. I have observed with much satisfaction that nothing has been made out as to the existence of unwholesome conditions in the wards of the Institutions which have suffered. Rather the general conclusion seems to have been that it spread by contagion only. This is in accordance with what I have contended for long. The evidence in sup-

port of the contagiousness of diphtheria appears to my mind most conclusive, and further, it so well explains the facts that it is almost difficult to find a place for the supposition that the disease is ever produced by defective drainage. If stagnant and drain-polluted water in close proximity with dwelling-houses could produce diphtheria, Rotterdam, Amsterdam, nay, even the Hague itself, ought to be depopulated. There are many houses, and even towns, in England also which ought to suffer severely. The disease, however, does not occur with any special virulence under such conditions, but breaks out in a fatal epidemic in some village or town of which the health conditions are, like the Hospital wards of St. Bartholomew's, unexceptionable. Many years ago I was compelled to pay attention to the laws of spreading of diphtheria in consequence of its occurrence at Haslemere and its neighbourhood, and amongst my own family and relatives. It then passed from house to house without the slightest regard to sanitary conditions, and appeared to be as purely a matter of contagion as an epidemic of measles.

It becomes exceedingly difficult, when once the possible range of the effects of contagion is realized, to feel confident that such a disease as Diphtheria has any other cause. Untrained minds, we well know, accept evidence easily as to the efficiency, as a cause, of any influence which is obviously present. Miss Nightingale, in spite of her intelligence and her frequent intercourse with medical men, held firmly that she had often known small-pox originate from bad Hospital arrangements. The anti-vaccinators often express the same creed, and almost invariably contend that variola can be prevented from spreading by attention to sanitary laws of the same kind as is successful against typhoid fever. Whilst, however, I venture to contend that when diphtheritic inflammations become epidemic they do so in virtue of their contagiousness, I would by no means place this malady in the category of the exanthemata and contend that it cannot be originated *de novo*. On the contrary, the evidence seems to me to support the belief that it is a form of catarrhal inflammation beginning, like all true catarrhs, in cold-catching, and developing its own

material of contagion just as the commoner forms of catarrh undoubtedly do.*

The conditions under which Plague spreads by contagion are worthy of our special notice. It is believed on excellent evidence that little or no danger is encountered in a short interview with a plague-patient. It is only those who remain some considerable time in the atmosphere of a plague-inhabited house who are in risk of receiving it. Physicians rarely take it from their patients, whilst, when under the old and barbarous rules for prevention of spreading all the members of an infected house were compelled to remain within its doors, it was but seldom that any escaped. A physician of extensive experience in the disease, who became himself the subject of it, is reported to have assured his friends, "You may come and see me and talk to me without risk, only you must not stay long." In this feature of requiring prolonged exposure we have a strong contrast with small-pox, measles, and scarlet fever, any one of which may be taken by a passing whiff of a patient's breath. It suggests the probability that the bacillus of plague is easily killed by exposure to ordinary air, and thrives only in the moist, effluvium-laden atmosphere of rooms. All the facts respecting it favour this belief, for it spreads where houses are crowded, and is thus said to be a "disease of the miserable." In large, well-ventilated houses it appears to have but little power, and the knowledge of this fact constitutes one of the principal sources of security as regards any future epidemic in England.

It seems certain that the virus, or fomites, of plague can be carried about by a person who is not himself suffering from it. The same is notoriously the case with that of erysipelas. Very possibly it is so with all the exanthemata. In the case of erysipelas it is well known that the surgeon's hands or coat-cuffs, &c., are a source of great danger to operation cases and to his midwifery patients. Puerperal fever is probably in a large majority of instances produced in this way.

* See ARCHIVES, Vol. i. page 307.

The lectures recently given by Mr. Watson Cheyne as Hunterian Professor at the Royal College of Surgeons were of much interest in demonstration of the easy artificial production in the lower animals of tuberculous disease of bones and joints. Following the practice of injecting human tuberculous matter into the nutrient arteries of bones, he proved that all the phenomena witnessed in spontaneous tuberculosis in man could be produced. By this plan of course all injury to the bone itself is avoided. Nor is any special proclivity in the animal necessary for the success of these experiments. The supposed immunity of the goat from tubercle upon which an absurd proposal for treatment has recently been based, is effectually disposed of by the fact that other experimenters as well as Cheyne have habitually employed these animals. Although, however, it would appear probable that the inoculations of tubercle may produce active tuberculosis under almost all conditions, yet it by no means follows that there are no predisposing conditions which are influential in every-day life. The immunity of almost all wild animals from spontaneous tubercle is a fact never to be lost sight of. Here again, as in the case of plague, we seem to get a hint that free exposure to fresh air is prejudicial to the life of the bacillus. In dealing with the topic of tubercular affections of bones and joints in the human subject, Mr. Cheyne, although asserting the invariable presence of the parasite, did not at all ignore predisposing influences. I was much interested to hear him speak of scrofula as one of the most important. This is the definition which I have myself repeatedly tried to give to the word, "that state of constitution which favours the development of tubercular diseases" (see Archives, Vol. ii. p. 209).

The introduction of diseases of vegetables as a subject for a course of Lectures at the College of Surgeons was, I believe, a novelty. In the hands of Mr. Plowright it has been a complete success. His lectures on some of the parasitic affections of plants and trees were listened to with great interest and attention. The marvellous phenomena of heterœcism were, amongst many other topics, well illustrated. That some

discovery in this direction awaits us which shall explain the relations of ringworm and alopecia circumscepta I feel very confident. Every week's additional experience confirms me in the belief which I have long held, that the one is a consequence of the other. Yet the interval between the two may be many years, and is indeed rarely less than several.

It is much to be hoped that the great attention which the bacillary forms of vegetable life now claim will have for one result the restoration of the study of plants to its proper place in the medical curriculum. It was a great mistake, a definite step backwards, when botany was omitted from the subjects taught in our medical schools. It is really a subject not only of enchaining interest, but of the utmost use. We need to understand not only the part which vegetable organisms take in disturbing the health of animals and of man, but very important parallels to the latter may be found in the parasitic diseases of vegetables themselves.

The history of the potato-disease is in some of its features not dissimilar to that of true plague. The special fungus which causes the former can develop only under certain medium conditions of temperature. It is so with the hypothetical particulate virus of plague, which was for long held to be incapable of germination in the tropics, and concerning which it is still admitted that both great heat and great cold destroy its vitality. Thus, in some hot countries plague prevails in spring, and ceases when summer is well advanced, to return again, however, next spring In cold ones the reverse is the rule; it begins in summer and ceases in late autumn. The remarkable manner in which plague lingers as an infrequent, or sporadic, disease for long periods and then suddenly bursts out as a wide-spread epidemic, is exactly like what we witness in the potato-blight. The latter has never wholly left us since its first introduction, but has prevailed extensively only during certain favouring seasons.

ON THE CANCEROUS PROCESS AND ON NEW GROWTHS IN GENERAL.

(*Continued from page* 144.)

An example of contracting Scirrhus of Breast—Both Breasts affected.

By far the most remarkable example of the form of scirrhus which contracts and atrophies which I have ever seen occurred in the person of a lady who was sent to me from Southampton. She had suffered from cancer of the right breast first, and the other subsequently, the beginning having been more than thirteen years ago. She had never had any open ulcer, but both breasts had disappeared, so that in each instance the nipple only remained. The latter was not reduced in size, but was retracted at its base and held down firmly to the chest wall. It is to be understood that every trace of the mammary glands had disappeared. On the right side, the whole mammary region was occupied by a thin, smooth, glossy scar, which extended backwards on the side considerably behind the mid-axillary line. Near to this large scar there were several other, quite isolated, patches of scar-like tissue, about the thickness of parchment, slightly rigid, and quite smooth and glossy on the surface. These were movable on the deeper parts, and in each instance the border of the scar was slightly elevated and presented a sinuous rolled edge like that of rodent. There was not a trace of ulceration anywhere, nor, let me repeat, had there ever been. On the border of the left axilla there was a subcutaneous lump about as big as a hazel-nut: this was the only instance of the growth showing any material thickness; everywhere else it was as thin as parchment. Two or three glands might be detected in each axilla, but they were scarcely larger than horse-beans.

When Mrs. P—— came to me she was in a state of urgent illness from what I diagnosed pleural effusion, her right chest being apparently full of fluid. This was, however, probably of quite recent development, for she assured me that until about a month ago when she thought she had taken cold in a country walk with her children, she had been in good health.

The case is not only remarkable on account of its tendency to atrophy in the mammary glands themselves, but in the very peculiar features which the secondary growths in the skin assumed, and from the absence in all the many positions which were affected of any tendency to ulcerate. The serpiginous advance of the disease in the skin was, as noted, by a slightly elevated rolled edge like that of rodent ulcer, and it left behind it a thin scar, which, however, was probably not free from growth. I have seen rodent ulcer travel widely and very superficially and leave scar, but never, I think, wholly without ulceration. In the case of Mrs. ——, from near Bath, of which I have preserved a drawing, a process of disease travelled widely over one mammary region, presenting everywhere a rolled and elevated edge like rodent, but leaving the surface not in a condition of scar, but covered with level florid granulations. This case appears to me to be very analogous to the one now narrated, the difference being that in the one case cicatrization had followed the advancing disease, and the other a condition of persisting granulations. The latter were claimed by some who saw the case as a form of eczema of the nipple. It may be that some of the conditions which pass under the latter name are similar to those now described, and examples of a superficially spreading cancer of skin.

The sequel of the above case is of interest in reference to the diagnosis of fluid in the chest. As I have stated above, I thought that the pleura was almost full, and suggested to the surgeon by whom the case had been sent to me that tapping should be practised. This was done with great care and skill on two occasions, but no fluid was reached on either. It seemed clear that the dulness was caused by solid growth and not by fluid. This was the more remarkable on account of

the very slight tendency to growth externally. Mrs. P—— died about two months after the period to which my notes refer.

Cancer of Tongue following "white paint sclerosis" after a long interval.

A man named John G——, now aged 57, was under my observation at the London Hospital fourteen years ago, and a drawing was then made showing the state of his tongue. It was a case of abrasions and sclerosis of the tongue due to syphilis and smoking. I advised him not to smoke, and to a certain extent he abstained. There is now present (1891) on the left side of the dorsum an oval patch nearly an inch long, which is indurated, rough, and papillary. It is superficial, and there is not the least ulceration; its hardness is however very definite, and it has been increasing of late. There is decided enlargement of glands in the floor of the mouth, just within the angle of the jaw. The right side of his tongue is in the white paint condition. He has a little aching pain in the tongue, and occasionally a little itching. During the interval since I saw him he has not needed treatment, and has not had much advice for it.

There is not the least doubt that epithelial cancer has now developed, and the case becomes of interest, because I now possess two drawings showing the conditions with a fourteen years' interval. The first portrait shows large patches which are smooth and white, exactly as if paint had been thickly applied. With these in other parts are some abrasions. The second portrait shows definite papillary growth budding through one of the thickest patches. As the man has advanced towards senility so have the local processes developed towards cancer. It is to be feared that he has waited too long, for the lymphatic glands are now enlarged. It is needless to say that on the second occasion I advised immediate removal of the tongue and excision of the glands.

DISEASES OF THE EYE.

No. XV.—*High degree of Myopia, stationary through a long life, and in spite of much use of the eyes and enfeebled health.*

We are accustomed to hold so strongly the belief that overuse is the main cause of aggressive myopia, that it is well to ask attention now and then to exceptional facts. One of the worst cases which I have seen, in which the elongation of the globes advanced so as to bring about blindness with detachment of retina in comparatively early life, occurred in a costermonger who could neither read nor write. In the subjoined narrative we have a converse fact.

Mrs. D—— married at 21, and was then, so far as she remembers, as shortsighted as she is now at 58. She always passed her friends, and even her own children, in the street. Her sight was, however, excellent, and she used her eyes constantly. "If I laid my book down I always took up my work." Suddenly at the age of 58 she found the right eye defective, and saw "a cloud of gnats" before it. This was explained by a small hæmorrhage into the vitreous. Although up to this date Mrs. D—— had always boasted of the excellence of her sight, and been able to read print which others could scarcely see, I found in both eyes extensive peripheral lens changes, and a small opacity at posterior pole. She had never in her life used spectacles. Her myopia at 58 was —4″ (or 10 D). This case shows that excessive use of myopic eyes and abstinence from glasses may be coincident with stationary myopia. That the myopia had not increased is the more noteworthy because Mrs. D—— had, through ten

years of middle life, been frequently exsanguined by profuse floodings, and during the next ten had to encounter much sorrow through the long illnesses in phthisis of her two daughters. It may be noted that not a hair had turned grey, but she had become liable to general œdema (? myxœdema).

No. XVI.—*Eczematous Conjunctivitis.*

It is not often that one sees a good example of true eczema of the eye. I mean by that term a disease of the same nature as eczema of the skin. When eczema attacks the face, it very usually spares the eyelids. The case of Miss R—— of Blackheath, who was sent to me by Mr. Herbert Burton, appeared to offer a good example of this condition. She suffered from very severe eczema of the ears. The whole of each ear and of the region behind it was affected—the right ear the most severely. I was told that when an infant she had suffered from eczema of the scalp and face very badly indeed, but had got quite well with the exception that the disease lingered about her ears. On these parts, however, she had not suffered much of late years; the present attack was only of a few weeks' duration. The right eye was inflamed. The conjunctiva of both lids and globe was much congested and slightly swollen. The redness was less near to the margin of the cornea than elsewhere, and there were neither ulcers nor pustules. The edges of the eyelids and the surface of the skin for about a quarter of an inch from the edges was red and excoriated (eczematous). The eyelashes, although surrounded by eczema, were not specially involved—that is, there was no sycosis. The other eye was not affected.

No. XVII.—*Ophthalmitis (pyæmic?) after parturition—Recovery, with loss of the eye.*

I saw Mrs. C—— at Sydenham in consultation with Dr. Wilkinson, of that place. She had been confined two weeks before my visit. Her labour had been long and difficult, but she was believed to be doing well during the first two days, when she was subjected to a severe mental disturbance, after

which tenderness of the abdomen followed, secretion of milk stopped, and she became very ill. During the next week she was, as Dr. Wilkinson assured me, in a very critical condition, with rapid pulse, brown tongue, and great abdominal tenderness. About ten days after her confinement, a week from the beginning of her febrile symptoms, and at a time when the latter were beginning to subside, the left eye inflamed. She had great pain in it, and her sight rapidly became indistinct, the lids being also much swollen. At the time of my visit on Tuesday, June 20, 1871, the eye was quite lost; she could not distinguish light in the least. The cornea was hazy, the iris muddy, and the pupil occluded with lymph. There was considerable congestion of conjunctiva, and by effusion into the cellular tissue of the orbit the eye was pushed forwards. The upper lid was tense from swelling; indeed, the aspect of things suggested the possibility of an abscess in the orbit, but on careful examination I could not detect any evidence of such being present. At this date the abdominal symptoms had quite ceased, and our patient might be considered out of danger. The other eye was free from inflammation, and there had been no symptoms of joint or visceral mischief, other than those connected with the uterus. Our patient was a lady of about 30 years of age, who had previously borne several children. It may be noted that she had cried a great deal since her confinement, and that her friends were inclined to believe that this had excited the disease in her eye. There can be little doubt, however, that the ophthalmitis was due to blood poisoning, and was secondary to the puerperal metritis. It is curious, if we adopt this hypothesis, that the usual symptoms of pyæmia were absent, that the patient had had no very definite rigors, and that she made a satisfactory recovery. Her case may, perhaps, be suitably compared with those of panophthalmitis which we now and then see in children after chicken-pox, &c.

Mrs. C—— called on me two months later, having regained tolerable health. Her eye was quite blind, the pupil everywhere adherent; but the globe had not materially shrunk.

Cases of loss of the eye in connection with fatal puerperal fever are met with occasionally. Mr. McCarthy has mentioned

to me one which occurred whilst he held the obstetric appointment at the London Hospital. In this both eyes inflamed, and the woman had at the same time symptoms of pyæmia, from which she died.

No. XVIII.—*Syphilitic Keratitis in two sisters—Result fifteen years afterwards.*

I attended two girls, sisters, aged respectively twelve and ten, for interstitial keratitis. In both of them the attack was severe and protracted. The elder one had typical teeth, the younger one not. The elder one had synovitis of one knee, at the time of the attack in the eyes. I had an opportunity of examining these patients' eyes fifteen years afterwards. They had both of them enjoyed excellent sight ever since, and their corneæ were perfectly clear. I examined the choroids in each with care, and could find no trace of disease. The elder one at this latter date seemed threatened with a second attack, for a small but very definite salmon-coloured patch had formed on the uppermost edge of one corneæ. Neither of them had had any periosteal disease or any other ailment.

No. XIX.—*Syphilitic Keratitis—Both eyes lost.*

In contrast with the above I may just mention the case of a poor boy, Alfred Leach, aged 13, in whom both eyes were lost by syphilitic keratitis. The attack had lasted twelve months. His corneæ, when I saw him, were shrunken, and the globes collapsed. Loss of the eyes from syphilitic keratitis is of course a very rare event. That it does occasionally happen, however, this case proves. I have seen a few others.

MISCELLANEOUS.

No. XVII.—*On Intestinal Croup or Membranous Enteritis and its differential diagnosis from Gall-stone Colic.*

The following extract is from a paper by Dr. Richard Powell, published in 1820 in the "Medical Transactions of the College of Physicians."* It is possibly the earliest description of recurrent membranous enteritis which we possess. I am especially interested in it because the author believes that attacks of this nature are apt to be mistaken for those of the passage of gall-stones. Dr. Powell begins by stating "Whenever violent pain takes place in the epigastric region of the abdomen, exacerbating in paroxysms accompanied by sickness, yellowness of the eyes and skin, and urine, by clay-coloured fæces, and without any proportionate increase of action in the circulation, biliary concretions are supposed to be forcing their way through the ducts; and when these symptoms abate, it is inferred that their passage into the duodenum has been effected."

* I cannot resist the temptation to quote the title of the first paper in this volume, as indicative of the practice of the day, and of the degree to which the separation of medicine and surgery was then carried out. It runs, "*History of a Case of Strangulated hernia successfully treated by the application of Ice after the attempt at Reduction by the Taxis had failed,*" by —— ——, *F.R.S., M.D., Fellow of the Royal College of Physicians.* One of the most valuable papers is by Edward Stanley, then Assistant Surgeon to St. Bartholomew's Hospital and Demonstrator of Anatomy. These volumes of Transactions have excellent illustrations. As a hint to the present zealous and active President of the College and his colleagues in office, I will reprint the "advertisement" which appears on the fly-leaf of the volume:—"*The College of Physicians of London are ready to receive any medical papers which shall be presented to them, in order to publish the most useful. Papers intended for the Transactions may be sent to the Registrar.*"

After this the author proceeds to state that he has often been disappointed of finding a gall-stone in the fæces, and has found instead what he proceeds to describe:—

"In the cases to which I refer, this residue has exhibited a large quantity of flakes mostly torn into irregular shapes, and appearing to have formed parts of an extensive adventitious membrane of no great tenacity or firmness. In the first of the cases which came under my notice, this membrane was passed in perfect tubes, some of them full half a yard in length, and certainly sufficient in quantity to have lined the whole intestinal canal. In the others also the aggregate quantity has been very large, and it has continued to come away for many days, but it has been in irregular thin flakes of not more than two inches extent, and not, as far as I could discover, of the perfect tubular form (which would probably also have been broken down by the agitation in water, if it had existed on its first passage out of the body). I have definitely examined four such cases, in all of whom the leading symptoms have been similar, and have led me to suspect the passage of biliary concretions at the time. They have all been adult females, and have occurred in private practice. I had attended but one of these previous to this particular attack, and she had frequently suffered from occasional pain in the intestines and derangement of her powers of digestion, with flatulence and a sense of suffocation. She was always relieved at the time by mild opening medicine, and believed herself able to prevent the attacks.

The more violent seizures under which I saw all the patients, consisted in a sudden and excessive pain in the epigastric region, increasing in paroxysms very frequently, rather relieved by pressure of the patient herself at the time, but leaving great soreness and tenderness during the intervals. This state continued under four days; during it the stomach was very irritable, and the tongue coated and clammy. Jaundice came on at an early period, and the stools were white, brown, or somewhat greenish, and streaked in colours, until the films began to pass, when they were mixed with a full sufficiency of bile, but not at first of a healthy colour."

After some statements as to the great advantage which he had obtained from the use of laxatives, Dr. Powell adds:—

"The formation of adventitious membrane has not been so frequently observed in the intestinal canal as it has in circumscribed cavities; and I know not that any description of the symptoms accompanying such a state has heretofore been given. The appearance which comes nearest to it, both in resemblance and situation, is the membrane formed in the trachea under croup, but the symptoms are there more violent and destructive from locality of situation."

The suggestion occurs that it is possible that in some of these cases a *bonâ fide* attack of gall-stone colic may have been the cause of the membranous enteritis. The explanation of the severe pain suffered in the early stage is not otherwise easily given. It may be that Dr. Powell (and many others with him) was wrong in the expectation that all cases of gall-stone irritation are followed by the passage of the stone. He adverts to the well-known fact that in most cases in which calculi are found after death in the gall-bladder, all history of attacks of colic is wanting. It may, however, not improbably be the fact that many attacks of gall-stone irritation end by the slipping back of the irritating calculus. The bile itself of course passes in both directions at different times, and we may without difficulty imagine a stone impacted for a time in the first part of the duct, and causing irritation, but not so fixed as to be incapable of slipping back again. Be this as it may, it is important for us to know and remember that an observant physician, who was in the habit of carefully inspecting the feces, found that, in certain cases which he had diagnosed as gall-stone irritation, evidences of membranous enteritis were present, and that no stone could be discovered.

I have myself recorded in the Pathological Society's Transactions for 1857, Vol. IX., page 188, a remarkable example of long-continued proneness to void tubular exudation-casts of the large intestine. The paper is enriched by a detailed account of the microscopic characters of the casts, by Dr. Wilks and Dr. Andrew Clark. The patient, a lady of

49, was liable to alternations of obstinate constipation and diarrhœa. I have since then seen several similar cases, and can confirm most of Dr. Powell's statements.

No. XVIII.—*Spontaneous Gangrene of the Penis a quarter of a century after very prolonged exposure to severe cold.*

I know of no Medical Journal in which so much information is so agreeably condensed into so short a space as in the Reports of the Northumberland and Durham Medical Society. They are, in my judgment, models of what such reports ought to be. The Number which I have just received consists of only nine pages, yet it contains most valuable statements of evidence as to the non-importance of the supposed cancer-fungus, the comparative inefficiency of Koch's treatment of lupus; and the possibility of recovery from tubercular meningitis. It has also case-reports proving that injections per anum may pass the ileo-cæcal valve, and that ivory pegs may remain unaltered in the tibia for eight years. There are further an example of recovery after ovariotomy at the age of seventy; of a good result after excision of the rectum; and others of recovery after removal of the cæcal appendix, and after operations for fœcal fistula and for gall-stones by choleo-lithotomy.

The case, however, which has interested me most is one, by Dr. Hume, of spontaneous gangrene of the penis in a man who, nearly thirty years before, had lost both legs by gangrene after six days' exposure on a raft. He was sixty-six years of age when the entire penis passed into gangrene, and he was at the time confined to bed by subacute bronchitis. The organ sloughed off with but very little pain. Dr. Hume records that he can find no record of spontaneous gangrene of the penis excepting in connection with fevers. In recording a case (ARCHIVES, vol. ii. p. 250) in which an old gentleman suffers from disturbed nutrition in his hands and other conditions allied to Raynaud's malady, I urged that it was probably a factor of some importance that he had many years before been exposed to very severe cold and suffered from frost-bite. So also in Dr. Hume's case I should incline to believe that it was by no

means a mere coincidence that gangrene of the leg had preceded that of the penis, although the interval was so long. In the first place, probably both implied that the man was congenitally of feeble circulation, and in the second it is likely that the prolonged exposure which caused the legs to slough inflicted permanent damage upon the nutritional vigour of the blood-vessels, nerves, and tissues generally, from which they never wholly recovered. There is an important lesson in the case.

No. XIX.—*The effect of Imagination on the influence of Drugs.*

I have had a few patients who aver that they cannot take nux vomica, because it always makes them feel sick. They are usually more or less intelligent persons who read their prescriptions, and who lay stress on the word *vomica*, fancying that it has something to do with an emetic. Those who speak of it as "nux" only always like it.

No. XX.—*Ague before the days of Quinine—Cirsoid Aneurism—Liability to Catarrh, &c.*

"I had not been here two days before a Quartan Ague set on me, which held me for a year and a half without intermission, and a year and a half longer at Spring and Fall. The good days I had during all this sickness I employed in Study, the ill being spent in as sharp and long fitts as I think ever any man endured, which brought me at last to be so lean and yellow, that scarce any man did know me."—*Lord Herbert's Autobiography*, temp. 1620.

Lord Herbert (of Cherbury), in his entertaining autobiography, gives some further interesting particulars as to his own bodily peculiarities.

In childhood he had discharges from his ears. In middle age he believed that he grew an inch taller; his tailor first drew his attention to it. He thought that it was explained by a remarkable rejuvenescence and improvement in health which had followed on his recovery from the quartan ague above described.

He believed that he was of a lighter specific gravity than most men, having often weighed against those who were a head shorter "and in their bodies slenderer," and always "found himself lighter than they."

He states, "I have had through life, and have still, a pulse on the crown of my head." He believed that his perspiration and breath were exceptionally free from smell, although he used tobacco "against certain Rheumes and Cataares."

He states that he scarce ever felt cold in his life, "tho' yet so subject to Catarres, that I think no man was ever more obnoxious to it." After detailing these particulars, he adds: "All which I do in a familiar way mention to my posterity tho' otherwise they might be thought scarce worth writing." He lived 1562 to 1648.

No. XXI.—*An instance of Restricted Secretion from Skin and Mucous Membranes.*

In the autobiography from which I have taken the above extracts, Lord Herbert of Cherbury gives the following quaint description of certain peculiarities in Louis XIII. "His words were never many as being so extream a Stutterer, that he would sometimes hold his Tongue out of his Mouth a good while before he could speak so much as one word. He had, besides, a double row of Teeth, and was observed seldom or never to spit or blow his Nose, or to sweat much, though he were very laborious, and almost indefatigable in his exercises of Hunting and Hawking, to which he was much addicted. Neither did it hinder him though he was burst in his body, as we call it, or Herniosus; being equally insensible, as was thought, either of heat or cold."

No. XXII.—*A spreading Mole.*

A young gentleman, who was sent to me by Mr. Huxley, of Torquay, presented an interesting example of an aggressive mole. It affected the left parietal region and was of considerable extent, covering an area almost as large as a child's palm. It was almost flat on its surface, and about an eighth of an inch in thickness. It presented here and there, but especially

at its margins, little fleshy fingerlike projections, such as I have seen in what I have ventured to name the cock's-comb mole. It was everywhere quite pale excepting at its edges, where, as already stated, it was actively aggressive. Here the little fimbriæ were many of them distinctly vascular, and on being magnified showed small tufts of dilated vessels, exactly like those seen in lupus lymphaticus. I did not, however, detect any distinct vesicles. The fact that the disease was spreading at its edge probably showed some alliance with the last-named malady, or even with common lupus. It had not, however, ulcerated in the least. As the young gentleman is going to reside in Australia, I shall probably know nothing further of the case. My treatment consisted in a very liberal application of nitric acid.

No. XXIII.—*Attacks of Arterial Anæsthesia of the feet of such severity as to make it difficult to walk.*

I have suggested the term Arterial Anæsthesia for a form of numbness which results from defective supply of blood, and have distinguished it from loss of sensation resulting directly from the nerves, by asking attention to the fact that it is never located according to their distribution. The illustrations of arterial anæsthesia which I have thus far given in the Archives, have been exclusively in the feet. They have all been denoted by the remarkable phenomenon of numbness, limited by a line drawn round the foot a little below the instep. In some cases the numbness does not extend so high, affecting only the toes, but in all it is bounded by a circular line and involves equally all parts below it. It is emphatically anæsthesia *ab imo*.

The best illustrative case which I have adduced was from a patient in whom a popliteal aneurism became suddenly occluded, and the blood supply to the foot was cut off mechanically. Another was from a case of locomotor ataxy, a disease in which the symptom not infrequently occurs. I believe that this kind of numbness, as a temporary thing and due to functional conditions, is very common. A very

definite example of it has come under my observation since my last note.

A lady of 58, of very feeble circulation, with weak heart and diseased arteries, complained to me bitterly that whilst walking her feet would often become numb. "It is not," she said, "the whole foot, but all the front of it, as if it were across my knuckles in my hand" (showing me her hand). "Both feet go at once, and I lose feeling to such an extent that I feel quite insecure in walking." She added, "It comes on whenever I am in the least cold, or from any little shock. I never get through a day without it." This lady had, I found, been accustomed for more than a year to carry about with her the nitrite of amyl capsules, which had been prescribed for her on account of very alarming attacks of a sort of angina which she had formerly experienced. During these attacks she became, she said, deathly pale, and those who saw her thought she was dying. Under long continued use of a prescription containing nux vomica, digitalis, and æther, she has been for a year free from these attacks. During the last three months, however, the liability to loss of sensation in the distal portions of her feet has come on as above described.

These cases differ from Raynaud's phenomena in that the duration of the condition is far shorter, and thus no risk of gangrene occurs. The attacks may be over in a few minutes, or at most in a few hours. I am not aware that they are ever attended by lividity.

No. XXIV.—*On large Arteries in Elderly Persons.*

The Rev. Mr. C—— affords a most remarkable example of general enlargement of arteries. He is a short, thick-set, florid man, and by no means emaciated. I can, however, count his pulse almost anywhere, so general is the increase in size in his arterial system. The radial can be felt very easily on the back of the interspace, and the superficialis volæ on both sides beats so vigorously that it might be mistaken for the radial itself. His temporals are enlarged in a like degree. There is no great evidence of tortuosity of vessels anywhere. Those of his lower limbs appear to be equally affected with those of

the upper. Both anterior and posterior tibials can be felt with the greatest ease near the ankle, and are two or three times their normal size. Mr. C—— is in good general health; his heart is of course somewhat enlarged, but he does not suffer from any special cardiac symptoms. He is of gouty stock, but has never himself had gout. He is a man of great intellectual power, and has, I expect, lived with moderate freedom. He is sixty-three years of age. He has several times consulted physicians on account of sudden failures of memory and loss of speech. The two things have occurred independently of each other, and at different times. His loss of memory has chiefly been noticed at family prayers, when he would absolutely forget sentences with which he was perfectly familiar. His loss of words or inability to express himself clearly has several times much alarmed his wife. Once it occurred just when he reached home after some little fatigue in walking, and on another occasion in the night when he had got out of bed.

I feel sure that a condition of general enlargement of the arteries in persons past middle life is not a very unusual condition, and that it is often independent of heart disease. It does not in some cases appear to involve any special risks, excepting, perhaps, of arteritis and thrombotic plugging.

No. XXV.—*Milium in a Baby.*

Mr. I——'s infant had her face and front part of scalp covered with little white milium spots, none of them in the least inflamed. They were said to have been present from birth. There were a few on the neck, trunk, and limbs. The face was covered. It was asserted that there were not so many now as at first. The little white spots were raised, and evidently contained a minute speck of sebum. The child was suffering from inherited syphilis, but I doubt whether the milium had anything to do with that disease.

No. XXVI.—*Lumbago.*

The Germans call lumbago Hexenschuss or the witch's spell, in reference to the extreme suddenness with which its attacks

of disabling pain come on. Niemeyer tells us that the wry faces, contortions, and the curious expedients to avoid bringing on the pain excite laughter as well as pity. He speaks of the disease as a rheumatism of the lumbar muscles and of the lumbo-dorsal fascia. Ten or fifteen lines are all that he devotes to its description. Graves, however, the prince of clinical observers, treats the malady much more seriously, discussing its pathology and causation at considerable length. He had himself suffered from it, and he evidently thinks a lumbago patient ought at once to take to his bed, and be freely cupped. From the general tenor of his statements we might infer that the disease is both more common and more severe in Dublin than in Germany.

No. XXVII.—*Fibrinous formation in the Ileum—Perforation of Appendix with local adhesions, &c., but no fever—Death after a week's constipation.*

Dr. Markham Skerritt, of Bristol, has recorded in the Clinical Society's Transactions a remarkable case in which a fatal attack of obstruction was caused by fibrinous effusion into the ileum, three inches above the ileo cæcal valve ("exactly like the false membrane in croup.") There were also peritineal adhesions and an abscess cavity. The attack had lasted one week, and had been wholly unattended by fever. It had begun with pain and sickness. On the first day there had been diarrhœa, but constipation ever afterwards. It appeared almost certain that perforation of the vermiform appendix had been the starting point.

In commenting upon the obscurity of the symptoms, Dr. Skerritt states that in his experience febrile symptoms are often absent in serious abdominal cases, and writes: "I have seen, again and again, patients suffering from acute general peritonitis almost free from local and general symptoms."

No. XXVIII.—*Notes on the Indian climate as suitable for the permanent residence of Europeans.*

I obtained from Colonel M. C——, a very intelligent man who had lived much in India, some information in reference

to his experience of the Indian climate, and more especially as to whether the hill stations offered attractions as places of permanent residence for Europeans. He said that Europeans were settling there, retired officers, &c., much more frequently than formerly, but that it was the depreciation of the rupee, and not the climate, which was the inducement. The rupee would buy as much in India as ever, whilst if you brought it to England you lost thirty-seven per cent. of its value. Were the hill resorts good for children? I asked. He believed that hill-bred children were not a success. The rarefaction of the air, and the rapid changes from intense sun heat to intense cold, were very trying to invalids; and it was necessary to live most carefully both as regards clothing and exposure.

Seven thousand feet was about the height of the best stations. Was it not possible to find healthy places much lower down than this? I asked. Not much, was his reply; five thousand feet was the lowest range to be out of range of fever. The ravines of the mountain slopes, through which the roads of ascent lay, were many of them more unhealthy than the plains below. No places were more deadly as regards malaria than some sites of this kind half way up the mountains. (Exactly the same report was given me respecting ravines in Corsica when I was there some years ago.) Colonel C—— did not intend to retire to the hills himself when his time was up, but return to England. He had a prejudice against climates where the sun was very hot, while the air was very cold. He mentioned sleeplessness as a very remarkable and very constant phenomenon in new arrivals at the hills. He said that some persons would be for a week with scarcely any sleep.

It was customary to try and become acclimatized in this respect by staying for a week or two at a somewhat lower station, but this must not be done at anything less than 5000 feet. He mentioned halting places somewhat lower than this, at which he should consider it equivalent to death to sleep. As regards the insomnia caused by hill air, it is a well-known result in many persons in the Swiss mountains; and it even occurs to some extent in such places as Malvern and Buxton.

No. XXIX.—*Dr. Heuss' portrait of extensive destruction of skin and cellular tissue from Syphilis.*

It is remarkable how often by patient waiting and continued observation we are in the end rewarded by discovering a parallel to what had at any rate appeared to be, if not unique, most exceptional. Those who have visited the new Gallery of Illustration in the College of Surgeons Museum may possibly have observed a portrait of a woman with her amputated arm by her side. The latter is shrivelled, and the whole of its skin in a state of scar. On the patient's body in many other parts are large scars from destruction both of skin and subcutaneous cellular tissue. The portrait, which is, I must confess, but very poor as a work of art, is yet of great clinical value, for it illustrates a most extraordinary development of disease. It is from Heuss' Atlas of Surgical Illustrations. Its discovery at once brought to my memory a case of which the following are the notes.

No. XXX.—*An extraordinary form of serpiginous destruction of subcutaneous tissue and skin, with atrophy of muscles; the disease spreading slowly for ten years, and still in progress.*

The patient, a woman, æt. 56, describes the disease as having commenced ten years ago as small subcutaneous lumps, some of which suppurated and some spread. The first which showed themselves were on the shoulder. It would appear that a succession of these swellings formed. Large sores afterwards formed at various places. They healed under poulticing, and with no specific treatment. She was engaged at the time in a furnishing shop, and she thought that the disease was probably due to strains. It would appear that these subcutaneous abscesses gradually extended upwards and downwards, and that they involved the muscles as well as the skin and cellular tissue. The result has been the production of an extraordinary condition of things. The whole of the upper extremity, from the middle of the forearm to the base of the scapula, is in a condition of irregular scar. In many parts

the scar is exceedingly thin. It is thinnest of all just over the shoulder, and the deltoid muscle having been entirely destroyed, the margins of the acromion and the head of the humerus, with its tuberosities, can be easily seen under a scar scarcely thicker than brown paper. Yet the joint is not ankylosed, and its capsule apparently has not been interfered with. The coracoid process is quite visible, projecting under the scar. The morbid processes appear to have come to an end near the shoulder, but it is uncertain if they are not still spreading upwards. Her little, ring and middle fingers are drawn up into the palm.

The case which I have narrated was brought under my notice by a friend many years ago. She was never my own patient, and I saw her but once. It will be observed that it was a form of infective and serpiginous inflammation of the cellular tissue rather than of the skin. The latter was involved secondarily. In Dr. Heuss' case, mentioned above, there was a history of syphilis, but specifics failed to cure. In mine I could get no such history, and the sores had besides healed without specific treatment. There was nothing in the least like lupus of the skin, whether common or specific. Nor are either of the cases at all like any of the ordinary forms of scrofula. The tendency of the skin to shrivel and cicatrise was a most remarkable feature. Nowhere did it present the undermined ragged edges so often seen in strumous ulcers. On the whole, probably the most likely supposition is that both were instances of a serpiginous syphilitic inflammation of cellular tissue.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. LXI.—*A Cerebral Case for Diagnosis.*

A gentleman of 23 who, as a consequence of rheumatic fever, had valvular disease of heart and hypertophy, was one evening driving in a gig. Suddenly the reins dropped from his left hand. His companion took them and asked him to change seats. He tried to do so and fell on the splash-board, being weak in his left limbs. An hour later he got out of the gig with but little help and walked into the house. He was found next morning unconscious, and with the left limbs quite paralyzed and the left side of face also. On regaining consciousness, after a few days he was quite hemiplegic as regards motion, and sensation in the whole left half of body, limbs, and head was defective. He could not retain his urine or fæces, he was deaf in left ear, and had lost smell in left nostril and taste in left half of tongue. His sight, so far as he knows, remained perfect. He was six weeks in bed, and then gradually recovered. Eight months later he could walk fairly well, had recovered perfect hearing, smell, and taste, and the only trace remaining of his facial paralysis was inability to shut the left eye without shutting the other. His arm was still in a sling and its motions imperfect, but it was improving and there was no contraction. He was just beginning to use his fork at meals.

DIAGNOSIS.

Clearly it was a case of embolism of the right middle cerebral artery. In the first instance the obstruction was probably not complete. During the night, coagulation of blood around the embolic plug made the obstruction complete

and developed the hemiplegia. It is remarkable that the hemiplegia involved the tongue, face, and hearing. This implied that a large extent of cortex was deprived of blood. Recovery took place in part by restoration of the blocked channel, and in part by collateral circulation.

No. LXII.—*Nodi Digitorum and Gout.*

1. What is meant by the the term Nodi Digitorum ?

2. How would you distinguish between Nodi Digitorum and the chalk-stones of gout ?

3. Do conditions similar to those called Nodi Digitorum when met with in the fingers occur in other parts ?

4. How would you diagnose the conditions represented in the appended woodcut ?

ANSWERS.

1. Nodi Digitorum is a term used for the bony enlargements which occur about the joints of the fingers in cases of rheumatic gout. It was first employed by Heberden.

2. The enlargements of nodi digitorum are osseous. Those of gout consist of the deposit of urate of soda ; a mortar-like concretion.

3. Yes, the conditions which constitute arthritis deformans in the knee, hip, ankle, &c., are of the same nature as those which cause deformities about the joints of the fingers ; consisting of outgrowths from the articular extremities of the bones concerned, with other alterations in their shape.

4. The woodcut very clearly shows true chalk-stones as distinguished from nodi digitorum. The swellings are large

and rounded, and do not keep closely to the joints themselves. They are also very variable in size in different parts. Nodi digitorum are usually of much more regular and uniform development. They occur only in connection with the joints themselves, and never assume the large size and rounded contour of those shown in the woodcut.

No. LXIII.—*A Case for Diagnosis.*

A gentleman aged 30, who five years ago was under my treatment for syphilis, now complains that there is a mist before his sight in reading which obliges him to shut the right eye. He has no inconvenience in walking, it is only when reading; and the mist disappears when the right eye is closed. He finds himself habitually reading with the affected eye shut. He has perfect vision in the distance with each eye singly, but when he tries to read small print he finds the right eye a little defective. The ophthalmoscope reveals nothing. The pupils are of normal size, but possibly a little sluggish. He has no other nervous symptoms, but once, some years ago, had a temporary weakness in the right hand. His reading vision with his right eye is quite restored by a + 14″ glass. The condition referred to has been present for three months.

QUESTIONS.

1. What do the conditions described imply?
2. What may this symptom portend?
3. What other symptoms should be looked for?
4. What are the conditions which constitute ophthalmoplegia interna?
5. What should be the treatment?

ANSWERS.

1. The conditions described imply a recently developed inability to effect complete accommodation with the right eye (imperfect cycloplegia). Hence when the type is brought to the proper focal distance for the better eye it is too near for the other, and a mist is perceived.

2. It may be part of ophthalmoplegia interna and an early symptom of locomotor ataxy.

3. The other indications of ataxy should be inquired for. The pupils should be carefully examined from time to time as to their activity, and the knee-jerks should be tested.

4. The conditions which make up ophthalmoplegia interna are motionless pupil, neither contracted nor dilated, and entire loss of accommodation.

5. As the patient had suffered from syphilis, a long course of small doses of mercury should be given.

No. LXIV.—*Explanation of Woodcut.*

The portrait furnishes a good illustration of the large size to which parotid tumours sometimes grow. It is from a photograph, for which I am indebted to the late Sir William Ferguson; the patient being a gentleman from India, in whom the tumour had been slowly increasing for twelve or fourteen years. It was excised in King's College Hospital, and proved to be, as usual, partly fibrous and in large part

cartilaginous. I possess another photograph, given me by Mr. Edwards, of Keston, which shows a tumour at least three times the bulk of that exhibited in the woodcut. In Mr. Edwards' case it hung down upon the man's shoulder. In this instance it had been growing for more than twenty years, and although the man had retained good health through this time it finally caused his death by ulceration and sloughing.

These tumours begin over the parotid, but by their weight in process of growth they tend to travel downwards and leave the side of the face. It is important to remember that the larger they have become the more rapid is their growth. The great inconvenience which their mere bulk finally causes supplies a strong argument in favour of early removal by operation.

No. LXV.—*Rheumatism and Gout.*

1. Is the term Rheumatic Gout a correct one?
2. What is the distinction between rheumatism and gout in reference to the causes of each? Which is the more common?
3. What is the most characteristic pathological evidence of gout?
4. Do the tendencies to gout and rheumatism really mix?
5. Mention an instance in proof that the phenomena of inherited gout may differ from those of the acquired disease.

ANSWERS.

1. The term "rheumatic gout" is very appropriate to a large number of cases, since the patients are suffering from gout and rheumatism at the same time.

2. A patient is the subject of gout if he is liable to affections of his joints, fascia, eyes and other parts, in direct connection with articles of food. He is the subject of rheumatism if he suffers from similar affections in connection with changes of weather and exposure to cold and damp. Rheumatic liabilities are far more common than those of gout; and probably very few become gouty who are not more or less rheumatic also.

3. The presence of urate of soda is characteristic of a gouty

inflammation ; but probably many of the slighter forms of gout are unattended by any such deposition.

4. Under the influence of hereditary transmission, liabilities to both gout and rheumatism may become inextricably mixed and complicated, and peculiar forms of disease may be produced.

5. There is a peculiar form of recurring iritis, ending in destruction of the eyeball, which occurs only in the children of gouty parents. It is not usually associated with any of the ordinary phenomena of typical gout ; and there is never any proof of the deposit of urate of soda.

No. LXVI.—*Landry's Disease.*

1. What is Landry's disease ?
2. What are its causes, and what its pathological anatomy ?
3. What is the usual duration of the disease ?
4. May recovery take place ?
5. Is Landry still living ?

ANSWERS.

1. In 1859 Landry described an acute ascending paralysis which involved motion solely. Beginning in the legs, it ascends and implicates the trunk and arms, even extending to the muscles innervated from the medulla and pons. In most cases it ends fatally by paralysis of the respiratory muscles.

2. No special cause is assigned, and what is most remarkable, the disease has no anatomical lesion. No changes whatever have been discovered in the cord. Sensibility is but slightly impaired, and the voluntary muscles retain their electrical excitability.

3. The disease has an average of about ten days, but may end in death as early as the third.

4. In a few cases recovery has taken place.

5. Dr. Landry was born in 1826, and died in 1865.

No. LXVII.—*The Tonsils and their functions.*

1. Of what substance do the tonsils consist ?
2. Is it probable that they absorb or secrete ?

3. In what other regions is similar gland substances met with?

ANSWERS.

1. They belong to the lymphatic system, and consist of masses of adenoid tissue containing many vessels and lymph-channels.

2. Mucous glands are embedded in them, but they have themselves no proper excretory ducts. It is quite as likely that their function is that of absorption as that of secretion, but to some extent both may take place. Their crypts are lined by a thick layer of squamous epithelium.

3. Masses of similar tissue are found in the palate, pharynx, and root of tongue. They may perhaps be regarded as the birthplace of leuco-cytes (Hingston Fox).

No. LXVIII.—*Causes of Nasal Voice.*

1. Under what conditions does speaking through the nose—"nasal voice"—occur?

2. Does it always imply paralysis?

3. Of what local diseases may it be symptomatic?

4. Of what constitutional disease is it a frequent consequence?

ANSWERS.

1. If during speech the soft palate be not drawn up and applied to the posterior pharynx so as to shut off the nasal cavities, the voice will in part pass through the nostrils and produce the well-known nasal twang.

2. Its occurrence may imply either sensory or motor paralysis, or it may be only the result of habit.

3. It may also be due to perforation of the palate, to post-nasal adenoid growths, or to enlarged tonsils.

4. It is common in the paralysis which follows diphtheria.

No. LXIX.—*Morbus Coxæ Senilis.*

1. What is the nature of the disease to which the name Morbus Coxæ Senilis is applied?

2. What are its most conspicuous symptoms?

3. What are the conditions found on dissection of the joint?

4. With what disease is it often confounded?

5. Ought the subject of rheumatic arthritis to be allowed to use his limb? Ought splints to be applied?

ANSWERS.

1. This term is applied to rheumatic arthritis of the hip joint (rheumatic gout), which is most frequent in elderly persons.

2. The earliest symptoms are pain and stiffness at the hip. These gradually increase, the buttock becomes flattened, the pelvis more or less distorted, and the limb may be shortened. Creaking in the joint during walking is often conspicuous in the later stages. Inability to get at the foot for the purpose of putting on the boot is a very characteristic symptom from the earliest period.

3. These vary according to the stage of the disease. The growth of a lip, at first cartilaginous and afterwards bony around the articular edge, is one of the earliest. Subsequently fringes may develop in the synovial membrane, the articular cartilage may be absorbed, the head of the bone eburnated, the neck shortened, and osteophytes ("pedunculated outgrowths of bone") produced.

4. It is constantly confused with sciatica. Most cases which are diagnosed as persisting sciatica are really rheumatic arthritis of the hip.

5. The patient should be encouraged to walk about, and on no account should any splint or restricting apparatus be applied.

No. LXX.—"*Paralysis of the Kidneys.*"

I extract the following from a paper by Sir Henry Halford (1818):—"There is a disease at once so dangerous and so soon fatal, that every physician should be aware of it, the paralysis of the kidney. * * * I have seen only five instances of it in twenty-seven years. The last was about two years since; and as it was an exact copy of all the others * * * I will detail it shortly.

"A corpulent farmer, of about fifty-five years of age, was seized with a rigor. * * * He had not made water, it appeared, for twenty-four hours; but there was no pain, no sense of weight in the loins, no distension in any part of the abdomen, and therefore no alarm was taken till the following morning, when it was thought proper to ascertain whether there was any water in the bladder, by

the introduction of the catheter; and none was found. I was then called, and another inquiry was made, some few hours afterwards, by one of the most experienced surgeons in London, whether the bladder contained any urine or not, when it appeared clearly that there was none. The patient sat up in bed and conversed as usual, complaining of some nausea, but of nothing material in his own view; and I remember that his friends expressed their surprise that so much importance should be attached to so little apparent illness. The patient's pulse was somewhat slower than usual, and sometimes he was heavy and oppressed.

"I ventured to state that if we should not succeed in making the kidneys act, the patient would soon become comatose, and would probably die the following night; for this was the course of the malady in every other instance which I had seen. It happened so; he died in thirty hours after this, in a state of stupefaction.

"All the patients who have fallen under my care in this disease were fat corpulent men, between fifty and sixty years of age; and in three of them there was observed a remarkably strong urinous smell in the perspiration twenty-four hours before death. Only one of them had complained of previous nephritic ailment. He had suffered frequently, and had passed several small calculi, but there was no difference in the progress of his symptoms when the paralysis had once taken place."

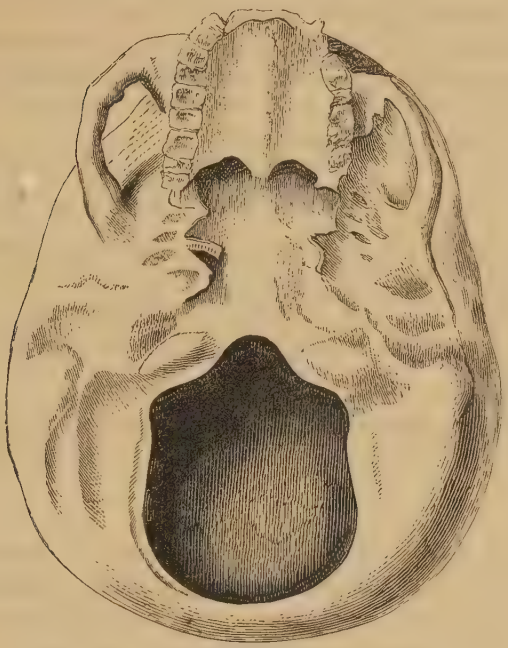
What was the probable nature of the disease in the cases described?

ANSWER.

The cases to which Halford gave the name of "paralysis of the kidneys" were in all probability examples of mechanical suppression of urine. These were most likely instances of single kidney, in which the ureter had got plugged by a calculus. Cases of single kidney are not uncommon. Sometimes it is a congenital condition, but more frequently one kidney has been destroyed by disease. It will be observed that Halford's statements as to his patients apply exactly to those most likely to suffer from stone. In one it is expressly stated that he had done so. The fact that the others had not does not militate much against the hypothesis suggested. I have myself recorded a case in which a gentleman died of retention with his only ureter corked by a small calculus. It was an example of congenital absence of one kidney, and this was his first attack of stone.

Mr. Clement Lucas has recently recorded a most successful case in which some months after excision of one kidney for stone symptoms of suppression of urine occurred. The pelvis of the remaining kidney was opened, and a stone found blocking the ureter. It was extracted, and the patient recovered.

No. LXXI.—*Explanation of Woodcut.*



The woodcut shows the base of a skull in which an enormous opening—such as would admit a child's fist—extends backwards from the foramen magnum. It is from a dried specimen, of an adult skull, which is preserved in the Musée Dupuytren at Paris. It is without history, but it may be plausibly conjectured that its possessor suffered from a large occipital encephalocele. There is no bridge of bone limiting the foramen magnum posteriorly, but in the recent specimen probably a strong ligamentous band crossed the space transversely in this position, and separated the spinal canal from the large orifice through which the encephalocele protruded. I have dissected several similar specimens in which this condition existed. They were all from young infants, and I am not aware of any other instance than the one to which the woodcut belongs in which a patient the subject of an encephalocele of this nature and size has survived to adult life. A

number of delineations of the conditions presented by such infants at the time of birth will be found in plate 47 of my "Illustrations of Clinical Surgery." Figure 5 in Plate XII. of Dr. Victor Bruns' Surgical Atlas shows a very similar base of skull, together with an outline portrait of the conditions presented during life. The patient was, however, as usual, an infant at the time of death.

No. LXXII.—*Mumps.*

The following points require further investigation in reference to epidemic mumps:—

When both sexes are equally exposed to contagion, do males always suffer most severely? Do they suffer more frequently than females?

What are the earliest ages at which it may occur?

Is its severity usually in ratio with the age, being greater in the older?

Do elderly persons ever suffer?

Is the evidence of inflammation of the ovaries ever definite, and when the complication arises are both ovaries usually affected?

Are the testes ever affected in young boys?

When head symptoms occur, is there usually pericarditis?

What are the conditions as regards brain and heart found after death from mumps?

Is there ever reason for believing that the disease has spread from the lower animals (cats, horses, &c.)?

After mumps is there any evidence of wasting of the parotids, as is so common in the case of the testes?

PLATE XXIX.

FUNGATING GROWTH ON SCALP.

This portrait shows the condition of the scalp in an elderly woman, in whom large masses of firm fungoid granulations had been produced, as was believed, secondarily to ulceration of a sebaceous cyst. There was, however, no clear evidence as to its earliest stage. The patient was under Mr. Rivington's care in the London Hospital, by whom the whole of the diseased growth was excised. The operation was done chiefly by means of Paquelin's cautery, but was attended by very profuse hæmorrhage. The wound healed well, and five years later there had been no return of the disease. At this latter date the patient, then seventy-three years of age, was under my own care in the London Hospital on account of senile gangrene of one foot, and made a good recovery after amputation through the thigh.

A microscopic examination of the parts removed showed conditions which were not easily distinguished from those of epithelial cancer. There had, however, never been any gland disease, and the fact that no tendency to recurrence was shown after the removal of such an extensive growth proved that the vital endowments of the tissue must have been very different from those of most forms of epithelioma. The tendency to fungate without any deep ulceration was the peculiar feature of the case. It belongs, I have no doubt, to the group of cases which Mr. Cock described many years ago in the Guy's Hospital Reports as occurring in connection with enlarged sebaceous follicles of the scalp. Mr. Cock has not, however, described any case in which the disease at all approached in extent that shown in this drawing. Its extent might indeed have been almost held to be a bar to operation, and the successful result is certainly an encouragement to surgical energy even under unpromising conditions.

This case has already been published as Plate LXIX. in my "Clinical Illustrations."

PLATE XXXIII.

TUBERCULAR SYPHILITIC-LUPUS.

This portrait exhibits the condition which was present in a woman who was under my care in the London Hospital, suffering from tertiary syphilis. It is a good example of the tubercular form of syphilitic lupus. That it was really syphilitic was proved by its complete disappearance under specific treatment. It will be seen that on the chest and fronts of shoulders there are large areas of superficial scar; and after the cure was complete the patient's face was left in a similar condition. The whole of the face as seen in the portrait is covered with elevated, tuberous masses. These are of very variable sizes, and in many instances have become confluent. They differ only from those of true lupus in that they present none of the brownish semitransparent material to which the term "apple-jelly" is appropriate. The occurrence of the disease in scattered patches on the chest, and the completeness of its cure in many of them, are also features which strongly suggest a diagnosis of syphilis.

I do not see any reason for attempting to avoid the expression "syphilitic-lupus." In the late stages of syphilis we undoubtedly meet with a great number of cases of lupus-like affections of the skin in which it is very difficult indeed to determine whether the disease is of specific origin or not. There are of course minor features of difference which aid the diagnosis, but not unfrequently the history of the case is what we have chiefly to rely upon. All the different forms of lupus vulgaris and lupus erythematosus may in turn be simulated. The most frequent is the serpiginous form, which creeps at the edge and heals in the centre, and to which the old name of "horse-shoe sore" is applicable. The portrait here given is not of that form, but of a much less common one. It corresponds to certain cases of lupus vulgaris, also not very common, in which numerous isolated patches or tubercles are produced. These are chiefly of the nature of satellites, as regards the parent one, and they in turn are productive of others. It was to this form, among the older nosologists, that the term "tubercular lupus" was applicable.

West, Newman chromo.

PLATE XXXIV.

SUPERFICIAL RODENT CANCER.

This portrait exhibits the condition produced by rodent carcinoma when it travels superficially over a large extent of surface, and nowhere shows any tendency to grow deeply. A large part of the temporal, frontal and nasal regions are seen to be involved. Attention is to be particularly given to the character of its edge, which is a sinuous elevated roll, everywhere alike. A careful inspection of the peculiar characters of this narrow wavy border will in almost all cases enable the observer to make a correct diagnosis of rodent ulcer.

It will be noticed that not only is there no deep ulceration anywhere, but that there is no development of papillary growths or granulation masses. The disease consists simply of the narrow "rolled" edge, which is steadily aggressive, and disorganises the skin, but leaves an ulcer which may soon cicatrise behind it. These extremely superficial conditions are exceptional in rodent cancer, and in all cases they are probably only temporary. Sooner or later the disease tends to pass more deeply. Nor is the absence of tendency to fungate and develop papillary excrescences by any means constant. In the present instance the patient was a woman of about thirty-five, much younger than the ordinary subjects of rodent. The disease had been in progress six or seven years.

West, Newman chromo.

APPENDIX.

THE LEPROSY PROBLEM.

The problem of Leprosy is not for the idle-minded. It is full of intricacy and difficulty. The facts are apparently conflicting, and they can be reconciled, if at all, only by the utmost patience and attention to detail. For those, however, who can bring to the task a fair stock of patience, a moderate knowledge of history and geography, and a good memory, the labour will not be without its interest, nor, I think, without its reward. However repulsive the disease itself in some of its phases may be, there is nothing whatever of that nature about its study. It is a sort of aristocrat amongst diseases, being possibly the very first which got a name; and the history of its prevalence, increase, and decline in different regions of our globe, is interwoven with that of civilization itself. A full account of it would indeed constitute a very important chapter in the history of the progress of mankind. Of its origin we know nothing. We find it common in the earliest periods of national life, — amongst the Egyptians for instance,—and many facts favour the belief that it has prevailed, not by transference from place to place but by spontaneous origin, in almost all parts of the world. In a general way it would seem that it has receded as the comforts of life have increased, and more especially as agriculture has been developed; but although undoubtedly in the main one of the curses of poverty and of savage life, it continues at the present day in certain localities to attack those

who have never deviated from a high standard of cleanliness and diet. Of our fellow-countrymen who go out into districts where it prevails, whether as soldiers, civil functionaries, or missionaries, a few return to us as lepers, and in them the disease is precisely the same, and runs the same course as it does in the native, and as it has done, so far as we can judge, in all past time.

The recent death from Leprosy of a devoted Roman Catholic priest, Father Damien, in the Sandwich Islands, whither he had gone to live amongst Lepers and to do them good, and the highly praiseworthy action taken upon that event by the Prince of Wales, have had the effect of strongly attracting public attention to this terrible malady. A National Leprosy Fund has been founded, with the double object of attempting to better the condition of Lepers in the British Dominions, and of trying by systematic investigation at home and abroad to solve the mystery of the cause of the disease, and thus do something effectual for its prevention. For myself, having for nearly forty years held an unwavering conviction that neither the cause nor the means of prevention are far to seek, I have hailed this public awakening with the deepest gratification. It is the thing for which I have longed. Although, of course, in many of its details, the disease is one for purely medical study, yet it is exceedingly important that the public mind should be well informed as to the main facts. Of a large section of the facts concerned, a non-professional mind is just as capable of judging as a physician ; and if its prevention is ever to be accomplished, it will be by the co-operation of the public and not solely by the action of medical men. I avail myself, therefore, with pleasure, and without the slightest feeling of impropriety, of the permission of the Editor of the ' Friends' Examiner,' that I should

endeavour to state the facts respecting leprosy as clearly as I can for the information of his readers.

The Nature of Leprosy.—This is now fairly well understood. It is the same disease in all countries, and everywhere it is quite different from all other maladies. It appears to have no near relations, and when it leaves any given locality it leaves it wholly. The first appearance of leprosy is known by an affection of the skin. Little brown patches appear which differ from all other skin diseases in that they are followed by loss of sensation. These multiply. Often this stage occupies years, and their subject meanwhile does not know that he is ill. Gradually spreading the whole skin becomes affected in a dreadful manner, the limbs become almost useless, and the patient passes into a state of most pitiable decrepitude. It is upon these, the latter stages, that all our popular notions of the disease are based, and it is of subjects in this stage that the inmates of leper houses chiefly consist. The disease is a very protracted one. It disables long before it kills, and on an average perhaps ten years of helplessness may be expected. If we count the introductory stage during which it is often not recognized probably five other years should be added. Not quite all lepers die of it. In a few exceptional instances recovery takes place, but it is usually with the hands and feet crippled, and often with the eyes much damaged. One of the most distinguished preachers in the United States at the present time is a gentleman of upwards of sixty, who, between the ages of twenty and forty, went through all the stages of leprosy and has recovered; he is, however, nearly blind and very helpless. Recoveries are, however, but few, and occur almost solely to those who are able to leave the country in which the disease began. It has recently been proved, following the researches of

Dr. Hensen, of Christiania, that a minute parasitic organism or bacillus is invariably present in leprosy. This discovery is of the utmost importance, and helps us to understand how the disease should maintain its individuality. In a sense this bacillus may be counted as the cause of leprosy. The question remains, What is the cause of the bacillus, and how does it gain access?

Leprosy in Ancient Times.—No one who recognizes that leprosy is in the main a very protracted disease of the skin, and that it is only to be distinguished with difficulty from others which resemble it, will need to be told that in times of medical ignorance the utmost confusion prevailed. Thus the word which our English translators of the Bible have rendered leprosy, included probably all chronic skin disease and many which were not chronic. This is made clear by the fact that the ritual of thanksgiving for *cure*, and that, too, after very short periods of treatment, forms the principal topic in the Bible references to the disease. The disease to which we now restrict the name is practically incurable, and although it is certain that the Hebrews had it amongst them, yet we must regard most of the Bible statements as belonging rather to other maladies. The same remark applies to all mediæval literature on the subject, and to much which is more recent. The old leper-houses contained many who were not lepers in our modern sense; and to this day the reports of its prevalence in India and elsewhere are rendered to some extent untrustworthy, by the fact that other diseases are counted with it. In particular there is a disease attended by white patches (leucoderma) which has nothing to do with leprosy, but is constantly confounded with it. No condition of general whiteness is ever produced by leprosy, and the "leper white as snow" of the Bible narrative, was

certainly not the subject of leprosy in the modern sense.

Making all allowance however for sources of fallacy, we may safely believe that true leprosy existed in Egypt, Phœnicia, and amongst the Hebrews, and that it has been present from time immemorial in such countries as China and India. Maritime discoverers have found it apparently indigenous in almost all lands. Seldom if ever have they found any extant tradition as to its date of introduction or mode of origin.

During the Middle Ages leper-houses abounded throughout Europe, and were especially plentiful in England and Scotland. Lanfranc, in the eleventh century, founded one in Canterbury; but long prior to that others had existed, and legal enactments in reference to the disease had been in force.* It has been erroneously supposed that the returning Crusaders were the means of introducing leprosy into Europe. This is a great mistake, for leper-houses had existed prior to the first Crusade. It was undoubtedly about this time that they greatly increased in number, and that attention was given to the disease; but it would be as erroneous to infer from this that leprosy was new, as to suppose that insanity is a novelty because lunatic asylums are in the main of modern origin. There is, indeed, no real evidence that the Crusades even increased the prevalence of leprosy. It is not probable that many Crusaders found their way to the coasts of Norway, yet it so happens that the first mention of leper-houses at Bergen occurs in 1256. In the fourteenth century leprosy began to decline in Europe generally. In 1434 we have record of the reduction of a leper-house in Durham because lepers could not

* Pepin in 757, Charlemagne in 789, and Rothar, King of the Lombards, even in the preceding century passed divorce laws in reference to leprosy. The first law that I know of in England was in 950, but there was a leper-house in Ireland as early as 869.

be found, and this fact probably represents the state of things over England and inland Europe generally. The disease lingered last in the Shetland and Faroe Islands, and it was not till 1742 that the Shetlanders were able to hold a thanksgiving service for its final disappearance. The last case in Cornwall occurred about the same date. From all other parts of the British Islands it had long before this wholly vanished. It is customary to say that the diminution of leprosy in England began with the Reformation; and if the fact were so, I should welcome it as lending some support to the belief that fish-eating is the cause of the disease, since with the change of religious belief came the abolition of fast days and of much compulsory consumption of fish. But the truth is that leprosy was declining in England more than a century before the Reformation; and although its disappearance may have been hastened by that event, it certainly was in relation chiefly with other causes.

Lepers at Present in England.—At the present day there are no indigenous lepers in England, Ireland, Scotland, or Wales, nor have any appeared for more than a century. The disease, so far as we know, has left no traces. A certain small number of imported cases are, however, always amongst us. Retired army officers, or soldiers, who have served in India or the Straits Settlements; missionaries, or their wives or children, who have lived abroad; children who have been sent home, from either the East or West Indies, for education in England; these several classes each supply a quota to the number of lepers who are at the present moment living scattered amongst our population. The nature of the disease is always carefully concealed both by medical men and their patients, and, there being in most cases but little visible to betray it, they mix with their friends as

usual. Children go to boarding-schools, husbands live with their wives and families, and hospital patients are admitted into the common ward.* No special precautions are in England taken against contagion, yet the disease never spreads.†

Immunity of the United States.—In connexion with this assertion of the disappearance of leprosy in Europe before the advance of civilization, it may be of interest to note that it has never developed in the United States. We have witnessed in North America that which the world had perhaps never before seen, colonization on an enormous scale without any initiatory stage of material hardship. The arts of life were taken across the Atlantic in fair perfection, agriculture was rapidly developed, and almost from the first bread and meat were cheap. Not only has leprosy never developed itself in the American continent, but the experience of Norwegian immigrants has fully proved that it cannot thrive when imported. Emigration from the leprosy districts of Norway has been very free, and many lepers at all stages have been taken from Norway to the States. It would be too much to say that they have usually got well, but this much is certain, they have not spread the disease either by contagion or heredity.‡

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* In making these statements I have no wish to excite alarm. The total number of lepers now in England is probably very small, and there is not, I feel assured, the slightest danger from their presence. It is to be remembered also that the presence of imported lepers in England is no new thing. They have been here in variable numbers, but under similar conditions to those described in the text, ever since the cessation of the malady as an indigenous disease.

† The only asserted exception to the above statement that I know of, is one in which a man is said to have actually worn the clothes of his brother who had died a leper. This case occurred in Dublin.

‡ These facts were established many years ago by a careful

Their children have been born free from taint, and the disease has in all cases died away with the individual sufferer. Leprosy cannot thrive, cannot indeed continue to exist, under the conditions of life which are found inland in the United States.*

The Present Haunts of Leprosy.—The disease is at present abundant on the west coast of Norway, north of Bergen, in the West Indian Islands, on many parts of the coast of South America, in India, Ceylon, China, Burmah, the Straits Settlements, and in Crete. It has smaller but possibly increasing *foci* at the Cape, in the Sandwich Islands, in Australia, at New Brunswick, and in California. It still lingers in very small and decreasing numbers in certain spots in Spain and Italy, in Palestine, and other parts of the lands near to the Mediterranean, at one or two in Sweden, a few in Russia and in Iceland.

As a general statement, it is true that all the places where leprosy now prevails are either on the sea-coast or near to rivers or lakes. An exception to this, probably not so great as it at first sight appears, occurs in the case of India. With the single exception of this proximity to water and to the means for obtaining fish, I know of nothing which the present haunts of leprosy can be said to possess in common. They are places most dissimilar as regards climate, food supply, and the conveniences of life. The inclement climate of New Brunswick and of Northern Norway, produces apparently precisely the same result as the tropical heat of Para, Burmah, and the West Indian Islands. In Norway, the poor fishermen who suffer from leprosy live

enquiry, conducted by Dr. Holmboe, of Bergen, and I believe they have been recently confirmed by Dr. Hansen.

* A small exception to this is to be made for California, where it has been taken by the Chinese; and still smaller ones for one or two other places, all on the sea-board.

under great privations, and are exposed to hardships of all kinds. In Brazil, the life of those who suffer from a malady which, be it remembered, is exactly the same in both places, is one wholly devoid of hardship, and indeed surrounded with luxury.

A very remarkable and instructive fact is to be noticed as regards the present leprosy haunts, that although the same malady everywhere, it affects in the tropics all classes, whilst in temperate regions it attacks only the poor. From temperate regions it vanishes before the development of agriculture, but in warm latitudes it shows no such tendency. No Englishman going to live in Norway need entertain the slightest fear of contracting the disease, but the risks, although still small, are very real in the case of Burmah and the two Indies.

I have in what has been said above omitted much that is of importance in reference to the nature and history of leprosy; but if I am not too sanguine, the reader who has followed me thus far will be in a fair position to form his own judgment of the main features of the problem. I will briefly summarize my principal assertions, most of which have already been discussed.

Leprosy is a well-specialised Disease. It is the same in all parts of the world where it occurs, and has probably been the same in all ages.

It appears to have no Allies. Gradations of severity are common, but no diseases, not actually leprosy, have as yet been proved to be in any degree connected with it.

It is not modified by Race. It sometimes, however, affects one race to the almost total exclusion of another living in the same district.

It is not for practical purposes Contagious, not even communicable from husband to wife.

It is endemic, that is it has its haunts. Where endemic, it sometimes affects certain classes, to the exclusion of others, whilst in other places it may attack all alike.

It affects both sexes.

It may occur at any age, but is chiefly a disease of early adult life.

It may wholly cease in certain localities.

It is possibly hereditary.

It has usually a long period of latency before its outbreak.

It is for the most part incurable, but sufferers may occasionally recover.

It may be produced in immigrants, or even visitors to leprosy districts; but usually only under conditions of complete conformity to the habits of the people.

It may occur sporadically; that is in populations but little liable to it, and then always occurs to some one who has been exposed to poverty and bad food.

It may perhaps help the discussion of our problem, and serve to prevent the extension of my paper to undue length, if I now avow my own belief in the form of two propositions. The first shall be that the evidence as to leprosy makes it certain *that the poison which produces the disease gains access to the body in the form of food.* It is self-evident that the disease, if contagious at all, is so in the feeblest possible manner. Its main cause of spreading is certainly not contagion. Nor does it spread solely or chiefly by inheritance, for an Englishman going to live in a leprosy district may acquire it in a year or two. It cannot possibly be due to any telluric emanations of the nature of malaria or otherwise, for it occurs in such different places, and it affects comparatively few in each place. It has clearly

nothing to do with temperature or climate. Nor is it a result of poverty or of neglect of the ordinary rules of life, for it attacks in both Indies persons who have enjoyed every comfort and have never deviated in any way from the strictest purity of outward life (young children for instance). It is clear then, I submit that the poison must be taken inadvertently in connexion with some kind or kinds of food. No other hypothesis can be suggested which in any degree adequately meets the facts, and this one does so. What articles of food are we then to suspect? Here my second proposition finds place. It is that *the evidence as regards this disease points to fish as being probably the vehicle by which the poison of leprosy gains access to the human body.* Under the term "fish" let it be understood that, for the present purpose, I include edible mollusks, crustaceans, and all living denizens of water, both salt and fresh. Let it be understood, also, that I suspect some kinds of fish much more than others. It may be that the poison is wholly absent from fish under most conditions, and present only under exceptional ones. It seems very probable that fish caught in the warm waters of the tropics is more dangerous than those from northern seas, and that all kinds of preserved or salted fish, or fish in a state of partial decomposition, are more risky than that which is fresh and sound. Lastly, it is possible that raw fish may contain a poison which is destroyed by cooking. Such, then, is the fish hypothesis of Leprosy. It is not new. In all ages, and in all countries where the disease has prevailed, fish has from time to time come under more or less of passing suspicion. In 1867 the College of Physicians published a large collection of evidence as to leprosy, collected at the request of Government from various parts of the British dominions. From this Report and from a

few other sources I will take almost at random a series of extracts bearing upon the question of food in general, and of fish food in particular, as being possible causes of the malady.

Iceland.

Dr. Holland, in Sir George Mackenzie's 'Travels,' 1812:—"The diet of the Icelanders consists almost solely of animal food, of which fish, either fresh or dried, forms by far the larger proportion. Scurvy and leprosy are common in the island, especially on parts of the western coast, where the inhabitants depend chiefly upon fishing."

'The College of Physicians' Report' (p. 43), quoting from Schleisner:—"I wish to call attention to the remarkable circumstance, that upon the whole north and east coast—tracts of country where no fishing is carried on — very few lepers indeed are to be found; while one-third of the whole number of the island are to be met with in Guldbringe Syssel, and there principally in one parish, where the chief fishing-stations are situated."

Russia.

Liveing writes:—"In Central European Russia leprosy is unknown; but it is met with at two opposite extremities of the Empire, namely, on the shores of the Baltic and the Caspian. Amongst the inhabitants of the northern shores of the Caspian, it is said to be chiefly confined to the Russians, who alone are engaged in the fisheries, while Kalmucks and Armenians generally escape."

Sweden.

Liveing (p. 42), quoting Dr. Hjort:—"In the last century 'there were large herring fisheries on the coast of Bohuslän, and at that time leprosy was exceedingly common in that district; but after the herring shoals in 1807 left that locality, and showed themselves on the Bergen side of the country, the leprosy almost entirely ceased on the coast of Sweden. The disease, however, seems to have accompanied the herrings to the Bergen shore, for it is precisely from that time that leprosy has increased so remarkably

in the western districts.' But while bearing in mind the change of occupation of the Swedes, consequent on the loss of the fishing trade, we must not forget that during the last half century they have made considerable progress in agricultural pursuits, and this has led to a general improvement in the condition of the poorer classes."

South America.

"Palgrave mentions salt fish as a main cause of leprosy among the South American Negroes (Creoles). He also disbelieves in its contagiousness. There is a small settlement in (? Dutch) Guiana, containing all the lepers of the colony and no healthy persons; they are isolated on the contagion theory." — ('Fortnightly Review,' Dec., 1875; Article on "Dutch Guiana.")

New Brunswick.

In New Brunswick the disease is prevalent chiefly among the poor of the French settlement of Tracadie and its neighbourhood. "In the winter their diet consists solely of salted herrings, and salt and dried cod-fish, frequently offensive from decomposition, potatoes, and at times salt pork; in summer they live on fresh fish; they have very little bread. They are chiefly employed in fishing, and agriculture is shamefully neglected."

Faroe Islands.

Liveing (p. 31), quoting Dr. Hjort, says:—"We learn from the Faroe Islands that the disease has there diminished, and is now almost unknown, since the great sea fishings were relinquished and more attention has been paid to agricultural pursuits."

Jamaica.

Dr. Bowerbank says:—

"*c.* The cleanliest and the dirtiest appear to suffer equally. The Jews, who are very cleanly in their habits, appear to suffer most.

"*d.* The Jews and coloured people generally consume a large quantity of fresh, as also of salted and kippered, fish." —(Coll. Ph. Rep. 12.)

BARBADOES.

Dr. Young:—"It is most frequent among the poorer classes. It occurs chiefly in low-lying, dry and hot districts, and along the sea-coast. The dwellings are small, and generally densely inhabited; the personal habits of the people not cleanly. The ordinary diet of the people is scanty, and consists chiefly of salted and fresh fish, with vegetable matters."

I quote the following from a diet-table of a Lazaretto in Barbadoes:—"*Breakfast:* Rice or corn-meal, or sweet-potatoes, or bread, with milk and molasses, or chocolate or coffee, *and 2 oz. of salt fish daily.*"

TRINIDAD.

Dr. Saturnin says:—"The almost entire use of salted meat and fish," &c., are aggravating conditions when the disease has once shown itself."

(Favouring circumstances):—

"*d.* Deficient and innutritious food. The poor live much on tainted fish and vegetables, such as plantains, yams, &c."

NEVIS, WEST INDIES.

Dr. Augustin says:—"Where the patient is dirty, and where meat is exclusively used for diet, or, in the case of Negroes, whose lymphatic system is affected by their food, which consists of vegetables and salt fish, the disease gains ground rapidly."

BAHAMAS.

Dr. Chipman says:—"I have a strong opinion that the poor diet generally of the lower classes, and the frequent use of fish and pork, increase the tendency to its development in the hereditarily predisposed."

ST. VINCENT.

Dr. Arnott says:—"I consider the ordinary diet of the population (consisting chiefly of salt fish, vegetables, corn-meal, fresh fish, with a very insufficient proportion of fresh meat and bread) to be unfavorable to the preservation of good health generally."

CHINA.

Around Shanghae. Dr. Henderson says:—"The country is intersected by small ditches and canals, and there is much

stagnant water, with many paddy-fields. Leprosy is not more common on the sea-coast than inland." "The food of the people consists chiefly of rice and vegetables; the lower classes eat large numbers of small crabs, which abound in the ponds and ditches."

Hong Kong. Dr. Dickson says:—"Fish diet, especially shrimps, believed to excite leprosy."—(Coll. Ph. Rep. xxxiv.)

Dr. A. F. Anderson, of Singapore, in his 'Report on Leprosy at the States Settlements' (p. 4), writes:—"As regards diet the Chinese are exceedingly obstinate. They will have salt fish and pork, with salted vegetables, in a state of putridity. The other native races are more amenable in the matter of diet; and I may remark here that in the treatment of Leprosy *diet is of the greatest importance.*" The italics are Dr. Anderson's.

CEYLON.

"An entirely fish or salt-fish diet, and want of cleanliness, invariably occur among the natives who are subject to the disease.—(T. A. P.)."

INDIA.

Bengal. Dr. J. Jackson (Hendon), late of Bengal, writes:—"In Bengal the disease is of the most frequent occurrence in the lowest class, especially the fishermen, who live chiefly upon fish, and that in a semi-putrid state." . . . . "Their diet is of rice, not the best, and fish with vegetables, made into curry or boiled. All the waters of Bengal abound in fish, and this forms a main article of diet; very few of the people take animal food. Their occupation is frequently that of fishermen."

Patna. Dr. Sutherland writes:—"Fish, as an article of diet, is used by every class of the natives, and, in a country where decomposition is rapid, it often happens that it is sold in a tainted state to the poorer classes. The use of tainted fish is believed, I think justly, to be a cause of leprous disease." . . . "Leprosy is not uncommon in the middle classes of natives."

Pooree. Dr. Durant writes:—"The ordinary diet of the poor people chiefly consists of boiled rice, vegetable curry, or fish, either fresh or dried," &c.

Nimar. Dr. Hunter writes:—"The ordinary diet consists of cakes made of wheaten flour or dâll, rice, ghee, &c.;

some low-caste lepers eat meat and fish, found dead, and devour generally what they can get."

Cuttack. Dr. Mantell writes:—"*d.* As regards the diet of leprous persons, I find they live chiefly on rice, pulses, and vegetables, and occasionally flesh. All agree in saying that the eating of fish increases the disease; and it is only when they have given up all idea of being cured that they become callous, and make it an article of diet."

Mauritius.

(Aggravating conditions):—

Mr. Ford says:—"Poverty, close unwholesome dwellings, want of cleanliness and pure air, unwholesome food, as too much of fish, and above all of pork, especially its grease."

"The natives believe that the too frequent use of pork as a diet, as well as certain kinds of fish and fruits," are exciting or predisposing causes, as well as aggravating the disease when begun.

Grenada.

Carribee Islands. Dr. McIntyre says:—"My three patients lived in a healthy, inland, hilly situation, in comfortable wooden houses. They lived principally on a vegetable and fish diet, and were on the whole in comfortable circumstances."

British Guiana.

Dr. Reed says:—"The mass of the population live on vegetables,—as plantains, tanias, cassava,—salt fish, and salt pork."

Leprosy is common in certain parts of British Guiana, and there is a leper-house, from the diet-table of which I extract the following:—On Monday, salt fish, 5 oz.; Tuesday, ditto, 2 oz.; Thursday, ditto, 2 oz.; Friday, ditto, 2 oz.; Sunday, ditto, 6 oz.*

I feel almost sure that those who read this list of quotations, and take them in connexion with what has gone before, will be inclined to exclaim, "Can

* My reason for giving the dietary of leper-houses is, first, to illustrate the food-habits of the district; and secondly, to give a hint as to why the disease is regarded as so incurable.

there be any doubt?" Is it not clear that fish-eating is the cause? How comes it that medical men familiar with such facts have not long ago warned the public, and thus prevented the spread of this horrible disease? There is, however, I must now hasten to admit, another side to the question and another class of facts. So far as I know, the fish hypothesis meets the facts fully in all parts of the world excepting India. Although it is true that we encounter leprosy in communities where no great excess of fish is taken, and in individuals who will assert that they have never been especially fond of it, yet, if we accept the proposition that the special poison may occasionally be present in an active form and in small quantities of fish, there is no great difficulty encountered in cases of this kind. It is at any rate clearly possible that fish may have been the cause in them also, and against the enormous mass of evidence which appears to connect the disease with fish they count for little. From India, however, we get another class of facts, or at any rate of assertions. We are told that certain castes are forbidden by their religious prejudices from ever eating animal food of any kind; that there are districts in which fish cannot be obtained, and which yet suffer from leprosy; and, which is yet more to the point, that of the inmates of leper-houses many will tell you that they never in their lives tasted fish. So seemingly strong are these facts that I have, I must admit, never yet met a medical man who had practised in India who could be got to listen with patience to the fish theory. The instance of a certain tribe, the Somalees, who, having come to the conclusion that fish was the cause of leprosy, determined to abstain from it, and did so, yet still continued to suffer, is constantly quoted. Thus, then it would appear that the tables are turned, our

argumentative labour lost, and that we are as far as ever from the discovery of the cause of leprosy.

Is it, however, really so? Are the difficulties which are cited in the case of India really such that we ought, as reasonable men, to at once abandon the hypothesis? I admit their force, but I am not convinced. In the first place the main facts in India, as everywhere else, support the fish theory. As a rule there, as elsewhere, leprosy is a disease of the sea-board, of rivers, and of populations which consume fish. As a rule, those castes which reject flesh food suffer but little in comparison with those who take it. It is rare for high-class Brahmins to become lepers. On this all are, I think, unanimous. As regards, then, the occurrence of leprosy in certain districts, inland or upland, where there is little or no fresh fish to be had, I would suggest that although there may be but little, that little is probably—from the distance it has had to travel—very bad. In reference to religious prohibitions I would ask, Are they always obeyed? Mahometans, in spite of prohibition, do sometimes take wine, and some Jews do eat oysters and pork. It may possibly be the fact that Brahmins do sometimes take fish, and it may be that the fish thus taken, as it were surreptitiously, is precisely of the kind likely to be dangerous. I allude especially to potted fish and to compounds eaten as a relish, in small quantities but usually in a state of partial decomposition. We know the temptations which savoury condiments of this kind offer to the palates of those who are restricted to vegetable food. Next it is to be remembered that the creed in some instances forbids the taking of life, but does not forbid the eating of what is found already dead or of what has been killed by others. Here is a loophole of great importance. Nor must we forget how readily and how frequently the human conscience permits the

evasion of interdicts which are onerous. All these considerations being kept in mind, is it reasonable to accept as conclusive the statements of Indian lepers as to their own habits of diet, more especially when the truth would to them involve the confession of moral delinquency? Ought not the assertions to which I have referred to be carefully sifted on the spot, and in a sceptical spirit, before we allow them such force as should overthrow a conclusion which is so well supported in other directions?

There is a fact as regards leprosy in India which has always impressed me as a very suspicious one. It is that there men suffer much more frequently than women. It is the reverse, though with no great difference, in Norway, whilst in other places the two sexes suffer equally. Now if a disease were the result of an infraction of a ritual law as to food, this discrepancy is just what we should expect. Women are, all the world over, far more strictly obedient to such laws than are men. This is notoriously the case with the Jews.

As regards the supposed failure of the Somalees to rid themselves of leprosy by abstaining from fish, I cannot avoid a suspicion that we have not got all the facts. That they should have arrived at so strong a conviction that fish was the cause as to attempt to enforce abstinence, is to my mind a stronger argument in support of the theory than their failure is in the opposite direction. What more probable than that their abstinence was, after all, incomplete? Perhaps they still allowed themselves condiments, perhaps some abstained, and others unconvinced still took fish secretly. Clearly the district they lived in was very dangerous, and a few delinquencies may soon have led them to think their experiment a failure, and have induced relapse. We need a far more careful statement of the facts

than any which I have yet seen before I can accept their experience, as at present recorded, as of much value.

Other fallacies which I have not mentioned underlie our facts from India. In many instances they have been collected in part by natives and not well trained observers. Other diseases not really leprosy have often been counted as such. From distant parts it is easy for merely hearsay evidence to gain credence. What we need is a critical investigation of the facts on the spot, and this is one of the duties which the Prince of Wales' Committee will doubtless undertake.

Lest any should think that I treat the statements of those who record facts in opposition to my own creed with an incredulity which is unreasonable, I may mention that in conducting this enquiry I have had several very emphatic warnings as to possible error in printed statements. Many years ago, in reply to a letter of mine inserted in an Indian journal, Dr. D——, a well known authority wrote that the facts as to the population of the Straits Settlements were a confutation of my theory, for there the fishermen lived on bad fish and yet had no leprosy. Enquiry proved that leprosy was abundant there; yet Dr. D—— had travelled in the district and might be supposed to have known. Again, in trying to estimate the present consumption of fish in London, I found in the late Dr. Letheby's Cantor Lectures on Food, the printed statement that 4200 tons of fish are brought daily into London. Feeling sure that such a quantity would block the streets of the city, I made enquiry, and found, after some persistence, that there was a mistake, and that the quantity ought to have been given as 800 tons. The discovery of two such important and vexatious blunders has made me more determined than ever to keep to the safe rule of believing only what is probably true. As

regards some of the statements as to leprosy in India, the mind of the investigator may, I think, for the present, assume an attitude of healthy scepticism.

Such then are the facts as to the leprosy problem as seen through my spectacles. Speaking generally, all the world over the facilities for obtaining fish and a defective supply of other food go in ratio with the prevalence of leprosy. Excessive fish-eating has been and is a characteristic of most aborigines living on the seaboard, and in almost all ages and places those so situated have suffered from leprosy. Fish-eating diminishes with increase of population and the development of agriculture, and under these conditions we find that leprosy has vanished from almost the whole of Europe. If in the present day the disease appears at a fresh focus, it is always on the seaboard, *e.g.* the Sandwich Islands, New Brunswick and California.

Those who assert that poverty or hardship have, *per se*, anything to do with the beginning or the spread of the malady, and those also who suggest that contagion is an important factor, do so in defiance of the most incontestable facts. It is well nigh certain that leprosy is due to some kind of unwholesome food. The sameness of the result makes it certain that the cause must always be the same, Of all articles of food which it is possible to mention, fish is the only one which has been common to all the regions which have suffered from the malady. In almost all places and times where and when leprosy has prevailed, the observations of those who suffered have thrown suspicion upon fish.

In offering this brief summary of the facts, I am far from wishing it to be supposed that I think the problem solved. My desire has been to prepare it in intelligible terms for the consideration of thoughtful

and independent minds. I feel sure that I need not to the readers of the 'Examiner' urge that it is not a question to be hastily decided. It is surely one which should claim our most serious attention, enforced by the remembrance that upon its right solution depends the health and happiness of thousands of our fellow-men.

JONATHAN HUTCHINSON.

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